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MEDICAL ANNALS

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CAN WE WIN THE PEACE THROUGH SCIENCE?*

MAJOR GENERAL ALDEN H. WAITT

Chief, Chemical Corps, United States Army

The biggest question of the day is how to win the peace. Everyone who thinks at all has some idea about how to accomplish this, or how it should not be done. Although we tried disarmament after the first World War, there are still many who believe we should disarm. There are others who believe we should arm to the teeth and keep the peace by policing the world with the largest army, navy and air force that can be built.

Of course, in this democracy of ours the people are not going to tolerate a large standing army. How then are we to defend ourselves against an aggressor nation and maintain our democratic system in a world that is anything but friendly to the ideals we stand for? We can't have the biggest army, but I do believe that we can have the best. Size may not be important in the future, but quality will be all-important.

So long as wars are possible, we must lead the rest of the world in scientific military developments and be prepared at all times to maintain our peace by having the most effective means to defend ourselves. If we are properly prepared, we shall not have to resort to war.

I wonder if you realize that we won a very important war from 1941 to 1945 without having to fire a shot, but by just being prepared. Our preparedness to wage chemical warfare made it unnecessary for us to fight a gas war.

Let me tell you just a little about this. Back at the beginning of the War it was decided as a matter of high policy that although this country would not initiate gas warfare, it would be prepared to retaliate overwhelmingly should the enemy use gas. Consequently, we built tremendous arsenals and went into large-scale production of chemical agents. Since we received reports that the enemy was making similar preparations, we sent great stocks of gas munitions overseas ready to be used on an instant's notice.

However, when we made the landings in Normandy we were surprised to find no indications of enemy gas. As we pushed forward, German preparations still were not apparent, and, when we reached the Rhine, no gas stocks had been uncovered.

But, as soon as we crossed the Rhine, it became increasingly clear that all our planning and preparations had been more than justified. I went to Germany a few weeks before the surrender, followed the Armies forward until V-E Day, and after the surrender visited many of the chemical warfare installations in Germany. It was a great revelation. Once we got into Central Germany, Nazi gas installations and storage depots appeared in increasing numbers, and vast supplies of offensive gas munitions were uncovered.

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* Address delivered at the Banquet, October 2, 1946, during the Seventeenth Annual Scientific Assembly of the Society.

At Raubkammer in Northwest Germany I saw the great proving ground and testing installation of the German Chemical Warfare Service. It more than equaled the combined proving facilities of our own installations at Edgewood Arsenal, Maryland, and Dugway Proving Ground, Utah. At this tremendous installation, 50 square miles in area, the Germans had completely equipped target ranges, enormous buildings (called *Mess Hause*) in which they could measure concentrations from exploded bombs and shells, lavishly equipped laboratories and all facilities for decontaminating men, animals and equipment used on contaminated ground. There were veterinary areas with everything required for exposing and examining animals subjected to toxic gases and chemicals. There were large pilot plants in which large scale methods for the production of new gases were worked out.

At Muna-Ost I saw a depot stocked with artillery and mortar gas shells and gas mines. There were approximately 10,000 tons of shells and mines at Muna-Ost loaded with mustard, phosgene, nitrogen mustard, and other new gases. There were also 4,000 tons of bulk mustard in underground tanks beneath the floor of a large shell-filling plant.

At Oerrel I saw one of the chemical warfare depots of the Luftwaffe. Here there were 175 well camouflaged concrete bunkers hidden in a pine forest. Each bunker was filled with chemical air bombs. There were some 130,000 bombs at Oerrel, and many of them contained the new German agent, Tabun.

Tabun was one of the few effective new war gases developed during the War. It is very highly toxic, almost odorless, and very difficult to detect in the air when bombardment is going on. It affects the eyes, and the respiratory tract, and can cause systemic poisoning through the skin. Our gas mask and protective clothing gave protection against it.

At St. Georgen, near the Austrian border, I saw a similar installation with even greater stores of bulk gases and very elaborate plants for filling shells and bombs. In all, in the American, British and French Zones, there was located a total of about a quarter of a million tons of gas and gas-filled munitions.

Why didn't the Germans use it?

My answer is that they didn't use it because we were prepared and could have dealt them a blow with chemicals which might have been, and in my opinion would have been, decisive.

There is a tremendous lesson for the American people in the failure of the Germans to use gas. It proves that preparedness pays and that the nation ready for any emergency need not fear enemy attack. Treaties didn't count here, for we had signed no gas treaty with Germany or anyone else.

Make no mistake, Germany would have used that quarter of a million tons of gas if we had not been able to overwhelm her with our own toxic agents. Our preparations cost us millions of dollars, but the money was well spent. Our enemy spent more money and more manpower than we did on gas preparations. Our gas warfare investment provided an insurance that not only saved us delays in the final offensive, but saved precious American lives.

Preparedness, however, doesn't get at the root of the problem. It doesn't cure the war evil. We can't win the peace with armies. We can keep the peace because other nations may fear to attack us, but to win the peace the causes of war must be removed, and here is where science can help.

More than anything else, mankind desires security and happiness. Nothing strikes more terror to a man's soul than fear for his security.

There is little doubt that the suspicions and fears of the peoples of the world today are caused largely by a feeling of insecurity. Peace is a natural state which results from security and happiness.

The first important task, then, of science is to determine the underlying causes of unhappiness and discontent in the world. This perhaps lies largely in the province of the social sciences, sociology, geopolitics, economics and psychology. There are many angles. For example, the effects of population pressures must be studied and causes removed; farm land areas and productivity must be increased by scientific methods. Science must find ways of overcoming the famine and low subsistence areas of the world. The physical and biological sciences at the same time must raise the standard of living and the health of the world. All of this will take time, but it can and must be done.

I wonder if you saw the editorial "Science and Coöperation" in the *Evening Star* the night before last? It referred to Dr. Harlow Shapley's talk at Princeton University before the nuclear physicists. Dr. Shapley's idea is that "science operating in fields that know no national barriers can be a prime mover in bringing more unity to mankind. To this end he would establish great world-owned and world-operated laboratories and institutes in which scientists from every land would work together to wrest new secrets from nature by undertaking joint studies of diseases, the aging process, nutrition, the atom, the outer reaches of space and other concrete and abstract problems of vast practical and theoretical importance."

I am not prepared to say that we are ready to establish world-operated institutes as Dr. Shapley suggests, but I feel we are ready to contribute our basic scientific information to the world. The United Nations Commission for the Control of Atomic Energy has been assigned this very duty. I believe success in this part of the program can have greater long-range effect on the peace of the world than even the successful control of atomic warfare. The first term of reference for this Commission requires that an effort be made to extend between all nations the exchange of basic scientific information for peaceful ends. To me that is a bigger job and a finer job than controlling the atom.

The atomic weapon, if it could be controlled, might temporarily prevent war through the threat of its use. This control by threat of force would weaken as time went on. Peace cannot be forced. It will come when all men have reasonably equal privileges and opportunities to enjoy life. Science will eventually bring this about, and a free exchange of scientific information between the nations will speed up the process. It will gradually improve conditions which in themselves are causing war.

Today the scientists of the world are coming to the conclusion that basic scientific facts should belong to all and that abstract scientific information is not competitive. Such information must be given to everybody. I think you will be glad to know that many of us in the Army realize this. As a result of our military research during the past War, we have a vast amount of valuable scientific information. We are making it public as rapidly as possible. It is the policy of the War Department to release to science and industry all of its research findings and developments that can be released without injuring national security.

I want to tell you what we are doing about this and about some of these dividends which your Chemical Corps is declaring on your investment in national defense research, because they point the way to how the peace may eventually be won through science. The story of these dividends should be particularly interesting to you as medical men.

First, our work on rinderpest. Early in the War we feared that our enemies might spread rinderpest among our beef and dairy herds. This scourge of cattle, which sometimes takes its toll of people, has never appeared on the

American continent. However, it can be spread so easily that saboteurs could have introduced the disease with little difficulty. Do you remember the paper balloons which were blown over to our shores from Japan in 1944 and 1945? We were worried lest these might carry germs to start a plague among our cattle. Many of them dropped in Canada and the United States, and they were carefully examined by Chemical Corps and medical experts.

A joint U. S.-Canadian Commission on Rinderpest was formed as one of the first steps in attacking the problem and there was set up on an isolated island on the lower St. Lawrence River a joint laboratory where Canadian, British and American scientists worked together and quickly produced an anti-rinderpest vaccine in quantity. This first vaccine prepared from the tissues of infected animals, an expensive process, was ready to protect our cattle should the disease break out. None of the vaccine had to be used, but the studies at the isolated island resulted in a revolutionary large scale method for producing a new and superior rinderpest vaccine made from propagating the virus in fertile chicken eggs. This new vaccine has already checked one rinderpest outbreak in British West Africa. A ~~million~~ doses of the new vaccine have been furnished UNRRA for treating the infected herds of China. The discovery is a benefit to every place on the globe where rinderpest exists or threatens. It will help to relieve starvation in India, China, and the Pacific Islands.

One of our most important biochemical contributions was the isolation and crystallization for the first time of a pure bacterial toxin. This is the material you have been reading about in the papers recently. It is so poisonous that one ounce of it contains enough lethal doses to kill many millions of people if it could be administered to them, which, of course, it cannot. This toxin is not important because of its offensive value. It is important because it gives us a key to new knowledge of cause and treatment of certain toxic conditions and to the preparation and behavior of toxins.

Our scientists did important work with the new antibiotics. Important knowledge was gained about treatment of a number of diseases The data are now being made available to medical science.

The biological activities of the Services were primarily for the protection of our military personnel and citizens, but it goes without saying that we had to make our plans for retaliation had that been required. Should there ever be biological warfare, we must be prepared to cope with it. I can't make you any flat statement that the next war will be won or lost by this kind of warfare. I do say it is doing a great disservice to national defense if one takes the attitude that it is not practicable and not worth the research effort. Today a man is very reckless who says that any scientific method is impracticable when there are other intelligent men who believe in its practicability and advocate its development.

So far as biological warfare is concerned, we know certain things can be accomplished, and we have good reason to believe that far greater advances are possible. Today many of us see the great potentialities of the weapon, and I myself believe that it has great possibilities in war.

But let's get back to our contributions to science. In the Chemical Corps we study intensively thousands of highly toxic compounds. In order to develop protection we must know about every agent which could be used to destroy life of animal, man, or plant. It is inevitable that in our study of toxics we must produce technics and materials of great value to medicine.

At Edgewood Arsenal we have one of the finest laboratories for toxicologic research in the world, and our scientists working there have discovered that a number of the compounds that could be used to produce casualties can be applied to cure disease.

Early in the war we learned that the Japanese had developed and actually supplied grenades filled with cyanide, and our Intelligence reported that they were working on cyanide bombs and other munitions. It became necessary to provide the best possible protection against this agent. Our Medical Research Division found that Papp (para-amino-propiophenone), an old-time pain-killer, could alter the hemoglobin in such a way as to make it react with cyanide before this poison could do any damage to the system. Here we had a counter agent. Men treated with Papp could be protected for reasonable periods from the effects of cyanide. Papp offers similar protection in civil life to men working with the poison in industrial plants and especially in ships and buildings where cyanide is used to kill insects and rodents.

For years mustard gas has been considered our most important chemical agent. We sent tons of it overseas in bombs and shells and in bulk containers. Many will recall that in 1943 the Germans attacked the Port of Bari in Italy and sank a large number of ships in the harbor. One of the ships hit by the bombs was a freighter which was loaded with mustard gas munitions. The freighter was blown up and sunk. The mustard gas released mixed with fuel oil and floated on the water. Men swimming in the water were burned with the mustard and there were many casualties. The doctors reported that the victims appeared to be in a state of shock that did not respond to treatment and later found that there was a definite reduction in the white blood corpuscles. As soon as this report was received, work was started at Edgewood Arsenal, the effects were reproduced in test animals, and it was immediately apparent that reduction in white blood cells was caused by the mustard gas. At once our Medical Research scientists saw the possibility that mustard might benefit diseases in which there was an abnormal increase in white blood cells. Some of the new nitrogen mustards that they were working with showed greater blistering powers than the ordinary mustard, so they examined these and found that they were even more destructive of the white corpuscles, especially of the lymphocytes.

The important clue had now been given them, and it was only a step to try mustard-type agents on those diseases of the blood which are accompanied by an increase of white blood cells in the blood stream or glands. They were tried on Hodgkin's disease. The treatment seems to offer promise. There have been no cures yet, but the treatment gives improvement similar to that with X-rays. A hopeful new avenue of research has been opened and this chemotherapy is now being investigated by the Committee on Growth of the National Research Council. There are over 100 nitrogen mustards that have been synthesized. Only a few of these have been tried as yet, but the work is going on.

Bal (2,3 dimercapto propanol) is a substance that was developed by the British to counteract the effects of lewisite and arsenical war gases. Our soldiers were furnished a tube of Bal ointment which they carried in their gas-mask kit. Our medical scientists found that this material is not only effective against arsenical poison, but have demonstrated that it will counteract mercury poisoning. Bal has a striking action. The pure compound is prepared in peanut oil for direct injection. It gives prompt relief and generally quick recovery of even the most acute cases of mercury poisoning. It relieves most kidney damage and cures within a few days. Lives are now being saved every month, which might have been lost a few years ago, because of the discovery of this use of Bal. Bal is also useful in cases of arsenic poisoning from too rapid treatment of syphilis. Chalk this up as another dividend from our investment in chemical warfare research.

DFP (di-isopropyl fluorophosphate) is a nerve gas. It causes constriction of the pupil of the eye. Our research has found that it restrains the action of chlorinesterase which is linked up with nerve impulse transmission. This war gas has been used in the treatment of glaucoma with some success, and it has been found of limited use in myasthenia gravis. Another discovery which may be of great value to humanity.

(*Continued on page 55*)

EXPERIENCE WITH A SERIES OF FOUR HUNDRED AND FIFTY CASES OF PILONIDAL DISEASE AT A NAVAL HOSPITAL*

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In civilian practice, the surgeon's obligation to the patient suffering from pilonidal disease is to remove permanently the source of the trouble at a time when it is most convenient to the patient. The element of time consumed in convalescence is not of prime importance. It is the duty of the military surgeon during wartime to return his patient to active duty as quickly as is compatible with the unimpaired efficiency, comfort and general good health of the patient. With this one exception the problems confronting the civilian and military surgeon in pilonidal disease are similar. The following is the experience at the National Naval Medical Center with a series of 450 consecutive cases of pilonidal disease.

At this hospital it was decided that all cases of pilonidal disease be handled by the proctologic section exclusively in order to furnish a large concentration of these cases on one service and thus provide ample opportunity for intensive study of the disease. In the period of this study 450 consecutive cases of pilonidal disease were observed. These represented 29.4 per cent of all admissions to the proctologic service during that time. The average age of the group was 23.5 years. Males outnumbered the females, 402 to 48. However, it must be remembered that the percentage of males in the Navy was considerably higher than females, which accounts for the comparatively small number of women represented in this series (10.7 per cent). That the disease is rare in the colored race is emphasized by the fact that all of these 450 patients were white. The average number of sick days of the total group was 28.6 days. Previous operative procedures for pilonidal disease had been performed on 57 (12.7 per cent) of the patients. Of these, 42 patients (9.3 per cent) had been subjected to but one operation and 15 patients (3.3 per cent) to more than one operation. The highest number of previous operations performed on any one patient was 8. Complete information was not available concerning the various types of operative procedures employed on these patients, since many had undergone operation before entering the Navy.

All cases fell into 5 groups depending upon the treatment required. These were classified as follows:

1. Cases requiring no treatment.
2. Cases requiring conservative, nonoperative treatment.
3. Cases requiring minimal surgery.
4. Cases requiring incision and drainage.
5. Cases requiring more extensive surgery.

Cases Requiring No Treatment

Servicemen with quiescent, asymptomatic, pilonidal cysts or dimples are capable of carrying on their full duties. Therefore, operation was not sanctioned in cases of this type. In this series 65 asymptomatic cases (14.4 per cent) were encountered. All of these were returned to duty without loss of time. None of these patients returned to this hospital at a later date with symptoms.

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* The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or as reflecting the views of the Navy Department or the Naval Service at large.

† Now Proctologist, Yater Clinic.

Cases Requiring Nonoperative Treatment

A group of 17 patients (3.8 per cent) were admitted to the hospital but treated conservatively without operation. This group consisted of:

(A) Five patients who showed minimal inflammation of a pilonidal cyst. They were characterized by slight discomfort and redness of a mild degree about the sacrococcygeal area with no elevation in temperature. In all cases the signs and symptoms subsided after a course of warm Sitz baths, and these patients were sent back to duty after consuming on the average 4.4 sick days.

(B) Twelve patients who had undergone a previous, adequate operation but whose incision had failed to heal as a result of faulty wound hygiene due to a lack of proper postoperative supervision. In every instance the patients had been discharged from the hospital before complete healing took place and, for various reasons, were not supervised at regular intervals by a medical officer. All of the wounds were characterized by the usual features of poor hygiene, as shown by excessive, indolent, granulation tissue and masses of irritating hair growing into the wound from the skin edges. A copious, odoriferous, seropurulent discharge was always present and caused considerable maceration and irritation of the surrounding skin. All of these patients quickly responded to a simple hygienic routine which consisted of regular Sitz baths, frequently changed cotton or gauze dressings, and elimination of the granulation tissue as often as necessary to keep it below the level of the skin edges. The surrounding skin areas were kept free from hair by frequent shavings. On the average, 13.5 days were required for healing in these cases.

Cases Requiring Minimal Surgery

Minimal surgical procedures were used on 5 patients (1.1 per cent) showing incomplete healing following a previous operation. In these cases poor postoperative care also appeared to be responsible for the faulty healing. The wounds were essentially similar in appearance to those of the preceding group but were further complicated by the formation of pockets as a result of skin bridging over portions of the wound before complete healing had taken place from below. Under local anesthesia the skin bridges were trimmed away and the unhealthy granulations were scraped away until healthy fibrous tissue was encountered. No further operative procedure was carried out. Postoperative treatment consisted of the same hygienic routine as outlined for the preceding group. These patients were returned to duty well after averaging 26 sick days.

Cases Requiring Incision and Drainage

Pilonidal abscess was encountered in 86 patients (19.1 per cent). These were immediately incised and drained under local anesthesia. Warm Sitz baths were instituted 3 times a day, and the wound was carefully packed with dry gauze following each bath. Of the 86 cases comprising this group, 63 apparently healed solidly from the bottom of the infected cyst under this treatment alone, consuming on the average 23 sick days. The remainder of the infected group, consisting of 23 patients, following the incision and drainage, were later subjected to a more extensive operation, since it was felt that because of the presence of connecting sinus tracts or extensive excavation they could not be made to heal solidly from the bottom of the wound with incision and drainage and packing alone. The average time elapsing between the incision and drainage and the more extensive operative procedure was 6.3 days. After this amount of time had elapsed, it was considered that the inflammatory process had subsided sufficiently for further operative treatment to be practicable.

CASES REQUIRING MORE EXTENSIVE SURGERY

Three hundred patients (66.7 per cent) were treated by employing more extensive surgery. The types of operations and postoperative treatments used were as follows:

(*A*) *Unroofing.*—Sixty-seven patients (14.9 per cent) were treated by unroofing the cyst and connecting sinuses. Under spinal anesthesia the cyst and connecting sinus tracts were laid open. The skin edges were trimmed back so as to saucerize the wound. The cyst wall was scraped clean with a scalpel, but no attempt was made to excise it. Dry gauze was packed into the wound and firm pressure maintained by adhesive strapping. This so adequately controlled the bleeding that ties or sutures were unnecessary for this purpose. On the afternoon of the day of operation the adhesive strapping was loosened. The patient became fully ambulatory on the first postoperative day. The dressing was changed on the second postoperative day following a Sitz bath. From this point on Sitz baths were taken 3 times a day, each being followed by a clean dressing which consisted of the insertion of gauze or cotton into the depths of the wound. After 4 days granulations covered the exposed nerve ends and the patient experienced no further discomfort. The skin edges were frequently shaved to aid in wound cleanliness until complete healing had taken place. Further treatment consisted of eliminating excessive granulation tissue as found necessary. For this group 24.9 sick days was the average time of hospitalization.

(*B*) *Marsupialization.*—One hundred and seventy-seven patients (39.3 per cent) were treated by a marsupialization type of operation. The cyst was first unroofed as previously described and the skin edges fixed to the cyst wall with heavy no. 9 silk suture, the central portion of the wound remaining open. This was packed with vaseline gauze and a pressure dressing applied. The dressing was first changed on the second postoperative day and warm Sitz baths were commenced 3 times a day. Following each Sitz bath a dry gauze dressing was inserted into the wound. The patient's activity was restricted until the 9th postoperative day, when the sutures were removed. Following this he became fully ambulatory. Further treatment was the same as outlined above. This group averaged 38.2 sick days.

(*C*) *Excision en Bloc.*—Forty-four patients (9.8 per cent) were treated by an excision en bloc type of operation. Under spinal anesthesia, a large portion of tissue which included skin, cyst and all connecting sinus tracts was dissected down to the sacrococcygeal fascia and was removed en masse. Bleeding was controlled and the wound packed open. The postoperative care was essentially the same as that outlined in the unroofing type of operation. In spite of the large defect created, these patients were relatively comfortable. They became ambulatory on the first postoperative day. The average number of sick days in these cases was 47.7.

(*D*) *Partial Closure.*—Six patients (1.3 per cent) were partially closed. The unroofing operation, as described above, was performed. One or more long, shallow sinus tracts were found extending laterally for a considerable distance. It was assumed that the sinus tract represented a path taken by purulent material when an abscess perforated the cyst wall and was, therefore, not actually a portion of the original cyst. After scraping the floor of the sinus tract clean, this portion of the wound was closed by deep vertical mattress sutures of no. 9 silk. The central portion of the wound remained open. The postoperative treatment was the same as described in the marsupialization operation. This group averaged 35.5 sick days.

(*E*) *Complete Closure.*—Six patients (1.3 per cent) were subjected to a closed type of operation. The cyst and connecting sinus tracts were dissected en masse down to the sacrococcygeal fascia and the resulting defect closed in layers, silk suture being used throughout. These patients were confined to bed for a period of 11 days. During this time gauze pressure dressings were used. On the 11th postoperative day the sutures were removed and activity limited for 5 additional days. Until the skin sutures were removed the patients in this group experienced considerable discomfort. In half of these cases (3) the wounds became infected and it was necessary to remove the sutures and lay the wound open. The average number of sick days in this group of cases was 42 days.

TABLE 1

Distribution of the 450 Cases into the 5 Groups and the Data Pertaining to Each in Table Form

CASES GROUPED ACCORDING TO TREATMENT REQUIRED	NUMBER OF CASES	PER CENT OF SERIES OF CASES	AVERAGE NO. OF SICK DAYS	NO. OF KNOWN RECURRENCES	PER CENT OF KNOWN RECURRENCES
(1) Asymptomatic—no treatment	65	14.4	0	0	0
(2) Treated non-operatively	17	3.8	10.8	0	0
(3) Treated by minimal surgery	5	1.1	26.0	0	0
(4) Abscess treated by I and D alone	63	14.0	23.0	0	0
(5) Treated by more extensive surgery	300	66.7	36.7	6	2

TABLE 2

Type of More Extensive Operation Employed on 300 Cases and the Data on Each Group

OPERATION	NUMBER OF CASES	PER CENT OF SERIES OF CASES	NO. OF SICK DAYS	NO. OF KNOWN RECURRENCES	PER CENT OF KNOWN RECURRENCES
Marsupialization	177	39.3	38.2	3	1.7
Unroofing	67	14.9	24.9	1	1.5
Excision en bloc	44	9.8	47.7	2	4.5
Unroofing with partial closure	6	1.3	35.5	0	0
Complete closure	6	1.3	42.0	0	0

RECURRENCES

The known recurrences, after 2 years, are indicated in tables 1 and 2.

CASES TREATED WITH PENICILLIN

Penicillin was used in treating 39 open cases of all types by topical application in strength of 500 units per c.c. Dressings were changed 3 times a day and 5 c.c. of the penicillin solution soaked into the gauze or cotton dressings at each change. The patients appeared no more comfortable under this treatment, and no difference was noted in the appearance of the wounds thus treated and those in which penicillin was not used. For the 39 cases the average number of sick days was 32.6 (table 3).

TABLE 3

	NO. OF CASES	AVERAGE NO. OF SICK DAYS
Treated with penicillin	39	32.6
Treated with tyrothricin	112	32.8
Treated routinely (excluding asymptomatic cases)	385	33.2

CASES TREATED WITH TYROTHRICIN

Tyrothricin solution was applied topically in 112 open cases. These patients were allowed Sitz baths 3 times a day. Following each bath the wound was swabbed with an applicator soaked in tyrothricin solution. Dry gauze or cotton was packed in the wound, and this was saturated with the solution. Tyrothricin did not appear to alter the course of healing. The average number of sick days was 32.8 (table 3).

SUMMARY AND CONCLUSIONS

A series of 450 consecutive cases of pilonidal disease seen at the National Naval Medical Center have been presented. A difference in the problem between military and civilian practice has been pointed out. The methods of handling and grouping these cases at this hospital have been outlined. This review leads to the following conclusions:

1. Pilonidal disease is common in the Service.
2. It is rare in the colored race.
3. Quiescent, asymptomatic cases may not require operation.

(Continued on page 55)

MIGRAINE HEADACHE

Treatment of Fifty-one Patients with Dihydroergotamine*

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BARBARA FAKLER, R.N.
Washington

ERGOTAMINE tartrate is considered to be the best agent we now have generally available for the treatment of acute attacks of migraine headache.[1,2] In spite of its effectiveness, many patients must discontinue or forego its use because of a relatively high incidence of toxicity.[3,4,5] In view of this fact we are fortunate in now having available a new preparation, dihydroergotamine (D. H. E. 45), which is as effective as ergotamine tartrate and seems to be much less toxic.[1,6]

It was shown in previous reports[1,7] that ergotamine tartrate and dihydroergotamine were very successful in aborting or reducing the severity of acute attacks of typical migraine headaches. On the other hand, the results were quite poor when these products were used in atypical cases in which several of the features of typical migraine were lacking. For this reason this report is based only on cases of typical migraine.

Typical migraine is a periodic unilateral temporal or orbital pain with intervals of absolute freedom from pain between attacks. There usually is a definite hereditary background of either headache, epilepsy, or allergy. In many cases the attack is preceded by an aura in the form of scotomata, mental dullness, or blurred vision and is often accompanied or followed by nausea and vomiting.

In any discussion of migraine it must be pointed out that there are two phases to the treatment. The first is therapy for each individual attack. The second is treatment to reduce the incidence of attacks. This report is therefore concerned only with therapy for individual attacks of migraine headache.

CLINICAL MATERIAL

This study includes those cases of typical migraine treated during the 13-month period from September 1, 1945 to October 1, 1946 in a private medical practice. Each patient received a complete physical and neurologic examination which included urinalysis, complete blood count, serologic test for syphilis, and examination of the ocular fundi to rule out other causes for the headache. Roentgenographic examination of the skull was performed in one third of the cases.

Of the total number of cases, 45 were females and 6 were males. The ages ranged from 23 to 69, the average being 37. Two hundred and sixty-six individual headaches were treated in these 51 patients during the period of study. All of the doses were administered hypodermically, and the strength was 1 mg. per c.c. per dose.

Twenty-two of the 51 patients had received ergotamine tartrate before dihydroergotamine was available to them. Twelve of these patients had had repeated injections several times a month over a period of 3 to 10 years. They uniformly reported good results but desired to discontinue its use because of the fear of eventual untoward side-effects. The other 10 patients discontinued ergotamine tartrate because they had already experienced uncomfortable or alarming side-effects or because of poor results from the drug. None of the patients received ergotamine tartrate during the course of this study. The results and side-effects reported are the interpretations of the patients and are included to point out that ergotamine tartrate is very effective but can also on occasion be very toxic.

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* Supplied by the Sandoz Chemical Works, Inc., New York 14, N. Y.

RESULTS OF TREATMENT WITH DIHYDROERGOTAMINE AND ERGOTAMINE TARTRATE

The results of treatment were recorded as excellent, good, or poor. By excellent is meant complete relief of the headache within ½ to 4 hours. A good result was one in which the headache was reduced in severity and duration but not completely relieved. Poor results were recorded when the drug exerted little or no effect on the headache.

TABLE 1

Results of Treatment with Dihydroergotamine

RESULTS	NO. OF CASES	PER CENT OF CASES	NO. OF ATTACKS	PER CENT OF ATTACKS
Excellent	41	80	249	93
Good	4	8	4	1
Poor	6	12	13	6
Total	51	100	266	100

Results of treatment in the 51 cases during 266 acute attacks of migraine treated with dihydroergotamine are recorded in table 1. It is shown that 41 patients (80 per cent) obtained excellent results during 249 attacks. Four patients (8 per cent) obtained good results during 4 attacks, and 6 patients (12 per cent) had little or no relief from 13 attacks.

The effectiveness of ergotamine tartrate in the 22 patients who received the drug is recorded in table 2. Sixteen patients (73 per cent) obtained excellent results, 2 patients (9 per cent) obtained good results, and in 4 cases (18 per cent) the results were poor.

TABLE 2

Results of Treatment with Ergotamine Tartrate

RESULTS	NO. OF CASES	PER CENT OF CASES
Excellent	16	73
Good	2	9
Poor	4	18
Total	22	100

As stated above, these patients discontinued the use of ergotamine tartrate because of poor results or untoward side-effects. Many patients who use the drug successfully do not seek other methods of therapy. For these reasons the reported results do not give a clear picture of the value of ergotamine tartrate in migraine. I have no doubt that if each of the 51 patients had received the drug these results would have been as good as those reported by others.[1,8]

TOXICITY

When questioned thoroughly about symptoms that accompany the headache attack, the patients disclosed many interesting complaints. Mental dullness and confusion, nervousness, weakness of the extremities, paresthesias, and even paralyses occurred. Severe nausea, emesis and abdominal discomfort are accepted as being part of the headache. As long as the patient suffers the agonies of the actual head pain the above-mentioned symptoms may seem trivial indeed. However, when he obtains quick relief from his headache per se these other symptoms often linger on for several hours. He then may complain bitterly about these symptoms and even blame them on whatever treatment he has received for the headache. Without bearing these facts in mind an investigator could easily be influenced to look upon some of these complaints as actual toxic effects of whatever drug he is using.

SIDE-EFFECTS AFTER USE OF DIHYDROERGOTAMINE

Of the 51 patients treated with D.H.E. 45, 13 (26 per cent) reported side-effects (table 3). In no case were these considered severe enough to necessitate discontinuation of therapy. In 4 there was a localized burning sensation at the site of injection which lasted several minutes. Each of these patients also complained of 1 or more of the symptoms reported below. One patient reported pain in the back of the thighs and legs for 1 hour after the injection. Another patient noticed a weak drawing sensation of the legs, similar to her usual menstrual discomforts. Neither of these presented objective changes in the color or temperature of the extremities or in the amplitude of pulsation of the vessels of the feet. Two patients described a peculiar burning sensation over the scalp and neck and the feeling of the hair standing on end. All of these patients described reactions that were definitely foreign to anything they had ever experienced during an untreated headache. These symptoms, therefore, should be recorded as side-effects to the use of the drug. The other 9 patients had side-effects that were present during untreated headaches as well as after treatment with dihydroergotamine, but the side-effects were usually overshadowed by the severe cephalalgia. These side-effects consisted of nausea, marked emesis, abdominal distress, "groggy," "dull" or "thick" sensations in the head, nervousness, and a generalized, miserable aching sensation.

TABLE 3

Side-effects after Use of Dihydroergotamine and Ergotamine Tartrate

	D. H. E. 45 (51 CASES)		ERGOTAMINE TARTRATE (22 CASES)	
	No. of Cases	Per cent	No. of Cases	Per cent
Burning at site of injection	4*	8		
Pain in legs, fingers, and toes	1	2	6	27
Drawing sensation in legs	1	2		
Burning of scalp	2	4		
Nausea, abdominal distress, and vomiting	5	10	8†	36
Malaise	1	2	1	5
Dullness of head	3	6		
	13	26	10	46

* Each of these patients also complained of one or more of the symptoms listed.

† Five of these patients also complained of pains in the extremities.

TOXICITY AFTER ERGOTAMINE TARTRATE

Toxic effects from the use of ergotamine tartrate are also listed in table 3. Here again certain of these symptoms accompanied the headache even when no treatment was given. Of the entire group of 22 patients who had received ergotamine tartrate, 10 (45 per cent) experienced side-effects. Six patients complained of pains in the legs, fingers or toes, 8 patients reported nausea, vomiting or abdominal distress, and 1 had general malaise. Five patients reported 2 different side-effects. This accounts for the report of 15 symptoms in the 10 patients.

DISCUSSION

It must be stated again that this report is not intended to present a statistical analysis of the effectiveness of D.H.E. 45 as compared with ergotamine tartrate in the treatment of acute attacks of migraine headache, or of their relative toxic effects. Such an analysis is precluded because 10 of the patients in this series were treated with D.H.E. 45 after severe toxic reactions to ergotamine tartrate. Eight of these 10 patients reported side-effects after the use of D.H.E. 45 also. It is therefore evident that a large number of the cases were known to react unfavorably to ergot preparations at the start of the investigation.

None of the patients who obtained good results found it necessary to discontinue the use of D.H.E. 45 because of toxicity, as had many of the patients treated with ergotamine tartrate. The percentage of good results with the use of D.H.E. 45 was just as high as with the use of ergotamine tartrate. In view of these facts it is my opinion that D.H.E. 45 is now the drug of choice for the treatment of acute attacks of migraine headache.

In the course of this study many interesting observations on the uses and effects of D.H.E. 45 were recorded. The most interesting development has been its use in certain cases of gastrointestinal upsets which seem to be migraine equivalents. I have treated 3 patients who complained of recurrent prolonged episodes of nausea, vomiting and abdominal cramps. Complete examination in each case was entirely normal and no cause could be found for these episodes. One of the patients formerly had typical migraine headaches but had not experienced them for 5 years. The other 2 patients had a definite family history of migraine but no personal history of the disease. These attacks are now terminated within 4 hours after a hypodermic injection of 1 mg. of D.H.E. 45.

Koppanyi[9] is now conducting experiments on dogs which seem to furnish a physiologic basis for my observation. He injects D.H.E. 45 in doses of 0.5 mg. per kilogram of body weight intramuscularly. One-half hour later he administers the usual emetic dose of apomorphine and finds that the dogs exhibit no evidence of nausea or vomiting. It is his belief that dihydroergotamine depresses the central vomiting centers in the medulla. These results seem to indicate that we must use much larger doses of D.H.E. 45 to exert the central antiemetic effect than we are accustomed to use for the migraine attack. Further clinical applications of these physiologic observations are being investigated.

As stated earlier in the paper, the treatment of migraine is twofold. This report deals only with the treatment of individual acute attacks. My experience with the use of histamine intravenously and subcutaneously to reduce the incidence of attacks of migraine headaches will form the basis of a future report.

SUMMARY AND CONCLUSIONS

1. Fifty-one patients have been treated with the new drug, dihydroergotamine, during 266 acute attacks of typical migraine headache. Eighty per cent of the patients obtained excellent results, 8 per cent good results, and 12 per cent poor results.
2. Side-effects were reported by 13 patients (26 per cent). These consisted in burning at the site of injection, pain or drawing sensation in the legs, burning of the scalp, nausea, vomiting, abdominal distress, malaise, and dullness of the head. In no case was it considered advisable to forego treatment with the drug because of toxicity, nor did any patient request discontinuation of its use because of uncomfortable reactions.
3. Results of treatment and side-effects with the use of ergotamine tartrate are also presented and discussed.
4. It is concluded that the new preparation, dihydroergotamine, is the drug of choice for the treatment of acute attacks of migraine headache.

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BIBLIOGRAPHY

1. Horton, B. T., Peters, G. A., and Blumenthal, L. S.: New product in treatment of migraine; preliminary report. Proc. Staff Meet., Mayo Clin., 1945, **20**, 241.
2. Friedman, A. P., and Brenner, C.: Principles in treatment of chronic headache. New York State J. Med., 1945, **45**, 1969.
3. Comfort, M. W., and Erickson, C. W.: Untoward effects from use of ergot and ergotamine tartrate. Ann. Int. Med., 1939, **13**, 46.
4. Gould, S. E., Price, A. E., and Ginsberg, H. I.: Gangrene and death following ergotamine tartrate (gynergen) therapy. J.A.M.A., 1936, **106**, 1631.
5. Yater, W. M., and Cahill, J. A.: Bilateral gangrene of feet due to ergotamine tartrate used for pruritus of jaundice; report of case studied arteriographically and pathologically. J.A.M.A., 1936, **106**, 1625.
6. Friedman, M. D., and Friedman, D. A.: Dihydroergotamine (D.H.E. 45) in treatment of migraine: preliminary clinical observations. Ohio State M. J., 1945, **41**, 1099.
7. Horton, B. T., Peters, G. A., and Blumenthal, L. S.: New product in treatment of migraine. Proc. Central Soc. for Clin. Research, 1942, **15**, 91.
8. Dannenberg, T.: Comparison of dihydroergotamine, ergotamine and other agents in treatment of migraine. Permanente Found. Bull., 1946, **4**, nos. 2 and 3.
9. Koppanyi, T.: Personal communication to author.

THE TREATMENT OF GONORRHEA WITH STREPTOMYCIN

A Preliminary Report with Cure of Four Cases*

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ALTHOUGH penicillin remains the undisputed therapeutic agent of choice in the treatment of gonorrhea, strains of gonococci resistant to penicillin in vivo are not beyond the realm of possibility. Gonococci which have been made resistant to penicillin in vitro have been shown by Miller and Bohnhoff[1] to be susceptible to the action of streptomycin. These authors further found that a tolerance for streptomycin could be developed also and that gonococci resistant to either drug were susceptible to the other.

Mortara and Saito[2] found that 8 freshly isolated strains of N. gonorrhoeae were sensitive to streptomycin hydrochloride in vitro and were inhibited by 10 to 15 units (micrograms) per milliliter of medium.

If gonorrhea resistant to penicillin therapy should develop, as in the case of the sulfonamides, it would be encouraging to know in advance that another drug is available for treatment.

To determine the efficacy of streptomycin 4 men with gonorrhea, confirmed bacteriologically by smear and culture, were each given a dose of 0.1 gram of streptomycin sulfate† dissolved in 3 milliliters of physiologic salt solution at hourly intervals for 5 doses. All were observed daily for 3 days after treatment, and on the seventh and tenth days. Our criteria for cure were similar to those used in the studies with penicillin by Chinn and Gillick.[3] Three consecutive negative cultures within 10 days after treatment and the absence of, or marked improvement in, clinical findings were considered evidence of cure.

All 4 patients responded promptly within 24 to 48 hours by a reduction or cessation of the urethral discharge. Cultures, following prostatic massage, were made at each examination and in all instances were found to be negative. Dysuria, where it existed prior to treatment, disappeared within 24 hours post-treatment, and in all cases the urine was clear within 7 days.

The response to streptomycin in these 4 cases was similar to that found in penicillin therapy. No toxic effects were noted.

Blood levels of streptomycin in 2 of the 4 patients rose to 20 micrograms per milliliter 1½ hours after the onset of treatment. In 1 of these 2 patients the blood level rose to 40 micrograms per milliliter at the completion of treatment and remained at that level for at least 2 hours.

SUMMARY AND CONCLUSION

1. Four patients were cured of gonorrhea with 0.5 gram of streptomycin given in 5 hourly doses of 0.1 gram.

(*Continued on page 55*)

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* From the Food and Drug Administration, Federal Security Agency, and the Bureau of Venereal Diseases, Department of Health, District of Columbia.

† The streptomycin used was from a supply available to the Federal Security Administrator under the provisions of the New Drug Section of the Federal Food, Drug and Cosmetic Act.

THE ROLE OF THE PEDIATRICIAN IN POLIOMYELITIS*

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By virtue of the nomenclature of the disease, which in common parlance is labeled "infantile paralysis," the interest and aid of the pediatrician in its study and care may be taken for granted. The name just noted, however, is a misnomer, infants being relatively infrequent victims of the disease, children most commonly, while adults form a fluctuating percentage varying in susceptibility in different outbreaks and with geographical localities. The island of Guam some years ago sustained an epidemic which attacked the adult population only.

Moreover, poliomyelitis commands the attention and services of the pediatrician because its invasive stages, often as well as its entire course, may consist of somatic signs and symptoms alone, bearing the earmarks of a generalized infection of severity which may subside without paralysis or disability requiring the services of the orthopedist and the physiotherapist. The most severe and most fatal instances of the "bulbar" type lie almost solely within the purview of the general practitioner or his prototype who practices within the age group of the young.

The pediatrician is first to be called if poliomyelitis occurs or is suspected in childhood, since he is almost as frequently consulted during the prevalence of epidemics for the differentiation of a host of other conditions ranging from minor trauma to scurvy.

Although in this panel discussion the pediatrician occupies the position of rear guard on the team, that individual is sometimes called the "safety man," in football language, and such may be the term which fits him in the whole picture of poliomyelitis. He, in reality, is in the vanguard of the medical group which must be assembled to combat as far as we may the ravages of this serious and baffling disease. He it is who has first contact with the patient-suspect, nor do his duties stop here.

One may picture the role of the pediatrician in a tripartite capacity, to wit, his responsibilities to the patient, to the parents, and to the public.

Poliomyelitis must be viewed as a somatic disease and, in not a few instances, as a psychosomatic malady, since in its initial phases it certainly presents bizarre invasive symptoms attributable to disorder of many systems of the organism apart from the residual phase of neuromuscular affliction.

The pediatrician's initial and important role is in the sphere of diagnosis. In this respect one is often reminded of the aphorism of Sir William Osler that "experience is fallacious and judgment difficult," since early diagnosis is fraught with real difficulty. Fortunately, experience is most helpful and good judgment of paramount importance to the welfare of the patient.

Invasive signs affecting the respiratory or gastrointestinal tract, especially if associated with irritability, hypersensitiveness of muscles, nuchal or back irritation with early tension, together with fever and psychic anxiety, should arouse suspicion in the mind of the pediatrician, especially during the seasonal expectancy of the disease.

His knowledge of anatomy and physiology should be of sufficient scope to permit the proper evaluation of muscle spasm, paresis, or paralysis and should include awareness of the origin and insertion of muscle groups, the relativity of antagonistic muscles, as well as the course and distribution of nerve trunks with their terminal connections. These basic branches of medicine, anatomy and physiology, come into a rightful heritage in their application to the detection and treatment of poliomyelitis.

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* Presented as part of the Panel Discussion on Poliomyelitis during the Seventeenth Annual Scientific Assembly of the Society, October 2, 1946.

In early diagnosis, the pediatrician must call to his aid certain laboratory procedures, especially spinal puncture, but must also be able to evaluate the results of the latter when combined with the general clinical picture he observes. Many times the spinal fluid cytology is reported as showing "less than one cell," yet the clinician feels sure of his ground in a diagnosis of poliomyelitis, and correctly so.

Time does not permit a review of differential diagnosis in suspected cases, but it remains the lot of the pediatrician to determine not only the presence of poliomyelitis but also its absence, when examining suspects. In the latter aspect, he must be alert to the probability of an "occupational disease" of childhood. The occupation of the child is to play, usually displaying considerable physical activity in so doing. One must not forget that a painful muscle or a limping gait may be but the earmarks of the occupation of play with the minor trauma incident thereto.

When the diagnosis has been made of the presence of the disease, a second and much more important role falls to the pediatrician who now becomes responsible for treatment, because poliomyelitis does demand treatment.

Diagnosis must necessarily include not only the demonstration of poliomyelitis but the nature of the form and type with which one is dealing, since the pediatrician's duty is to direct that method of treatment which is proper and to interdict that which is not. The recognition of "bulbar" forms, the differentiation between predominant glossopharyngeal and vagal paralysis, the ability to note whether intercostal or diaphragmatic paralysis constitutes the embarrassment to respiration, whether or not to institute hot packs, prostigmine, the application of postural technics, and beyond all else, when and whether the child should be placed in a respirator as well as when and by what stages respirator treatment should be discontinued. The use of the respirator has saved many lives; its abuse has no doubt contributed as well to the loss of some. The feeding of the bulbar case, the prevention of aspiration drowning by the removal of secretions through the medium of postural or suction modalities, and the selection of how and when to use these methods of treatment are functions belonging in the realm of internal medicine.

To instance an occasion in which proper judgment in treatment was of paramount importance I shall cite the experience of an 11-year-old girl sent to the hospital because of serious bulbar poliomyelitis. The general practitioner, whose special attention had been given to hearts rather than to "bulbs," ordered the child immediately to have hot wet packs applied beginning on the evening of admission and continuing throughout the night. Needless to say, this child, who required intravenous fluids for an entire week because of paralysis of deglutition, was not benefited, but her life was actually put in jeopardy by the mechanics of wet, hot packing with the wrongful postural changes incident to their application. A prone, well inverted bed decubitus with constant aspiration of secretions and parenteral feedings were needed to save this life.

It is an obligation upon the pediatrician to seek consultative and associative aid from the orthopedist, nor should such coöperation be too little nor too late. However, the pediatrician should be imbued with the obligation, which is rightfully his, to outline and direct treatment during the acute period of the disease; to extend his interest in the "follow-up" during a convalescence which may be interminably long; and to give comfort and assurance to the child in the role of amicus curiae by means of his psychotherapy of sorts, which occupies a high place in the armamentarium of treatment, call it a combative of "mental alienation" or whatnot—all of these contributions born of his friendship for the child, quite often dating from birth to the day of affliction, have a power for therapeutic good which must be recognized.

To the parents, apprehensive, fearful, deep in the throes of emotional distress, this same role becomes most emphatically the pediatrician's duty. He must be the interpreter of the characteristics of the disease to the lay mind. He must emphasize that "many are called" but not all are "chosen" as inheritors of the crippling effects of the disease. He must explain not only the necessity for use but the prohibitions against employing various measures of treatment, e.g., the employment of the "iron lung," of which the laity have learned through the medium of the press and magazine columns, too frequently the vehicles for imaginative, highly colored and roseate reports of writers who are laymen columnists rather than wise physicians.

Lastly, there is an obligation to the public which shares in the fear of a malady which, like the Biblical wind, "bloweth where it listeth, and no man knoweth whence it comes nor whither it goeth." To allay public hysteria, to publicize measures of precaution which are at best based only upon experiences with other communicable virus infections and are as yet poorly defined—all such effort is due to a public which not only has a justifiable inherent interest in poliomyelitis, but which yearly gives generously to funds which are being used extensively for the aid and comfort of hundreds of victims of the disease and for the continued support of research through which the riddle of poliomyelitis may eventually be solved.

During our epidemic of 1944 the Poliomyelitis Committee of the Children's Hospital as a public relations service took occasion to invite to the hospital every city editor of the local newspapers for a "press conference." Discussion lasted for an hour or more, at the end of which the newsmen and newswomen were gowned, capped and masked in order that they might actually visit the wards and see what was being done for the care of the sick children. A frank understanding of the problems of hospital care with the assurances of its adequacy proved most beneficial to the public thus informed through the medium of firsthand information acquired by members of the press.

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President's Page

BEST WISHES for the NEW YEAR

At the beginning of a new year it is well to take stock of the achievements in the immediate past and prospects for the future. The year 1946 was studded with brilliant contributions to medical science, most of which will form a foundation for advances in the immediate future. Developments in chemotherapy, general metabolic, electrolytic, vitamin and endocrine balancing have contributed to improved control of pathologic entities and lend hope for constructive advances in the control of malignancy and the ravages of the passing years.

Economic and sociologic evolution have also wrought changes which, in my opinion, have caused unnecessary concern in the minds of many physicians of advanced years. At the same time, young physicians have participated unwittingly, and, I feel, too completely in actions not calculated to favorably influence their future. With respect to older practitioners, I have reference to the growth of prepaid medicine and group practice, which, in my judgment, have unnecessarily disturbed them. I believe these developments have been logical and desirable. Younger physicians have, on the other hand, been influenced by their experiences in the armed forces, and have shown susceptibility to arguments in favor of a regimented profession.

It is my hope that the New Year will witness an acceleration of the efforts of older physicians to inform themselves in regard to advances in the scientific and economic fields of medicine, and an ability to accommodate themselves gracefully to what is good in the new. May the youth aggressively and vigorously capitalize on the good features of the new and avoid participation in the unsound.

I extend to all of you my sincere wishes for the most interesting and progressive year in all of our scientific and economic activities. With your continued coöperation and support, we will go forward to greater achievements in 1947.

William P Herbst Jr

Editorials

THE GOAL OF REHABILITATION*

That new hope for millions may come out of the suffering and chaos of war is one of the paradoxes that conflict inevitably brings. It is a sorry truth, but none the less true, that through concerted efforts to annihilate man, we have learned more and better ways to preserve him. A striking example of this anomaly can be found in the wartime emphasis placed on rehabilitation in the successful treatment of mental and physical diseases.

The wartime programs of rehabilitation and convalescent services were founded by military authorities as a result of necessity. Manpower shortages were as acute in the early days of the war as in civilian life. In the dark days of early 1942, we could not afford to have the proportion of ineffective personnel increased by prolonged convalescence in which the patient did nothing to contribute to either himself or the mission of the military services. Nor could we afford to have the emotional reactions of the transition from civilian to military life in newly inducted hospitalized soldiers accentuated by a convalescent period of inactivity and boredom. And last, but not least, neither overworked medical staffs nor overcrowded hospitals could carry the unnecessary burden of tens of thousands of convalescent patients.

The average patient during a hospital stay suffers ten per cent of the time from pain and ninety per cent of the time from boredom. This is equally true of both civilian and military hospitals, though more devastating in the latter for there is less time to waste in war than in peace. The realization that wasted convalescent time could be converted into purposeful activity by a well integrated rehabilitation program with equal emphasis on physical reconditioning, psychosocial readjustment, and vocational guidance, led to the establishment of special convalescent hospitals by the Army Air Forces in 1943. These hospitals treated men, not diseases. Their purpose was to provide the combat-soldier with a laboratory of opportunity where he might regain not only health but the attitudes, habits and values compatible with normal behavior patterns that war had disrupted and distorted.

The success of the military services in the fields of rehabilitation and planned convalescence has demonstrated what can be done by planning and integrating medical care along with the ancillary sciences to provide treatment of the whole man in terms of his medical, social, vocational, economic and personal problems. A similarily comprehensive medical rehabilitation program is now under way in the Veterans Administration. Staffed largely by men and women who worked in military and naval hospitals during the War, this program will bridge the gap between the bed and the job by keeping the rehabilitation process continuous and uninterrupted from the time the man was wounded or injured until he is able to return to society as a self-sustaining citizen.

Both the medical profession and the general public are genuinely concerned with the problems which must be faced by the thousands of disabled veterans as they return to their communities, but few of us realize that our disabled veterans constitute only a small part of the total number of handicapped and disabled in this country.

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* This is the eleventh in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

This editorial is a summary of an address delivered before the Medical Society of the District of Columbia on November 13, 1946, especially prepared for publication in the MEDICAL ANNALS.

During the first four years of war there were approximately 17,000 amputations in the Army, but during the same period of time there were 120,000 major amputations from disease and accident in our civilian population. In 1940, according to the United States Public Health Service, the United States had some 6,500,000 disabled males between the ages of 15 and 64 years, men who normally would be income-producing. Each year 350,000 persons in this country are permanently disabled by accident alone.

We have seen, read and heard of the rehabilitation opportunities afforded men disabled in military service, but what happened to the 42 out of every 100 men who were unable to pass Selective Service induction examinations? What is being done for the two million persons in this country whose correctable physical disabilities prevent them from holding jobs? What happens to the 350,000 persons disabled annually in accidents? Where can the casualties of the home front go to receive the aid they need?

The problem of the disabled and handicapped is not a new one. War has only focused our attention on it and quickened the necessity for its solution.

Experience with physically and emotionally wounded soldiers has given us new knowledge and new tools in rehabilitation—the third phase of medical care. It has taught us that we must deal with the influence of disease upon the individual in terms of its economic, vocational, social and personal effects. It has shown us that in our search for new drugs, diagnostic procedures, surgical technics and laboratory methods, we must not overlook the extra-physical results of illness—the changes it creates in the mind and habits of the patient as well as his body. It has laid the basis for a new medical specialty which is adequately described by an old medical term "orthergasia," which literally means conditioning for normal function and adjustment—the goal of rehabilitation.

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SUMMARY OF READER INTEREST

Early in 1939, the editors of the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA decided to make a survey of reader interest in the ANNALS. This was done with fairly satisfactory results, some 15 per cent returning the questionnaires sent them. Many helpful criticisms and suggestions were offered with beneficial results.

Seven years later (October 1946), the editors undertook another study, primarily for the purpose of ascertaining present satisfaction with the ANNALS. Incidentally, this study provided the Managing Editor with material for a talk given to editors of state medical journals at the Conference of State Secretaries and Editors held in Chicago on December 7, 1946.

Because there were only two weeks in which to make the survey, returns were not as large as they might have been if more time had been allowed. A questionnaire was sent out on October 29, 1946, with the notation that the returns must be in by November 15, the date on which they were to be tabulated. Of necessity, the deadline was adhered to by the editors. As expected, a number of questionnaires were received thereafter, but were not included in the tabulation. However, an examination of them reveals that had they been, they would not have altered the picture.

At the present time the ANNALS has a total circulation of 1,900. Some 1,350 physicians receive the journal. It was this latter group that were surveyed. By November 15, 179 had returned their questionnaires. Questions asked and the replies are summarized below:

ARE YOU A "COVER-TO-COVER" READER OF THE MEDICAL ANNALS?

Yes	64
Almost 100%	41
Occasionally	3
No	71
Total	179

IF NOT, WHICH OF THE FOLLOWING INTEREST YOU? (Figures include cover-to-cover readers)

Scientific Material		177
Articles	144	
Clinico-Pathological Conferences	119	
Case Reports	122	
Editorials		139
President's Page		102
Articles and Comments on Medical Economics, Social Problems, and Other Matters of General Nature (the column "In and Out of Focus" is included in this category)		133
Washington Physicians of Yesterday		94
Reports of Boards and Committees		105
Veterans' Affairs		93
News and Personals		127
Membership		89
Announcement of Meetings		124
Book Reviews		99
Correspondence		84
Obituaries		96

WHAT MATERIAL, NOT NOW PUBLISHED, WOULD YOU LIKE TO SEE INCLUDED?

Completely satisfied	14
Made recommendations	69
Total	83

Recommendations were made that the following be published—

Reviews of recent medical literature
"Questions and Answers" on scientific subjects and controversial issues
Research material available through National Institute of Health and other health service institutions
More public health material
More case reports
Lists of recommended scientific reading
More illustrations
More reports on clinico-pathological conferences
Reports on standardization of names of pharmaceutical preparations
Abstracts of scientific papers and articles (many voted for this one)
Articles on laboratory findings
Articles on mental hygiene
Reviews of literature in specialties
Reports on scientific activities in the District of Columbia
Abstracts of papers presented before local societies
Summaries of all scientific programs presented by the Society
Articles devoted to recent advances in medicine
Reports on newer drugs
Scientific work being done in District hospitals
Reports on births and marriages
Announcements of scientific meetings
Humorous column

WHAT MATERIAL WOULD YOU OMIT?

Completely satisfied	36
Made recommendations	31
Total	67

Recommendations were made that the following be omitted—

Articles on medical economics	5
Scientific articles shortened or "weak ones" left out	4
Book Reviews	3
President's Page	3
Personals	1
Correspondence	2
Veterans' Affairs	1
Detailed reports of Boards and Committee	2
Clinico-pathological conferences and case reports	4
Washington Physicians of Yesterday	4
Filler material	1
Advertising (cut down)	1

DO YOU LIKE THE APPEARANCE OF THE ANNALS?

Yes	155
No	3
Made recommendations	11
Total	169

IF NOT, DO YOU HAVE ANY SUGGESTIONS?

The 11 who made recommendations objected to the picture on the cover of our journal, did not like its size, or its format.

DO YOU THINK THE LAYOUT OF THE TEXT MATTER IS ATTRACTIVE? HOW CAN IT BE IMPROVED?

Completely satisfied	94
Comments	27
Critical	6
Total	127

Among the constructive criticisms were the following—
- Do not "continue" articles to the back of the journal
- Too much waste space
- Introduce some color
- Use of a picture on the cover is not dignified

DO YOU PATRONIZE ADVERTISERS IN THE ANNALS?

Yes	124
Those who said "yes" listed 1 to 23 firms whom they patronize	
No	17
Not in practice or not interested in the advertisers	
Total	141

COMMENTS:

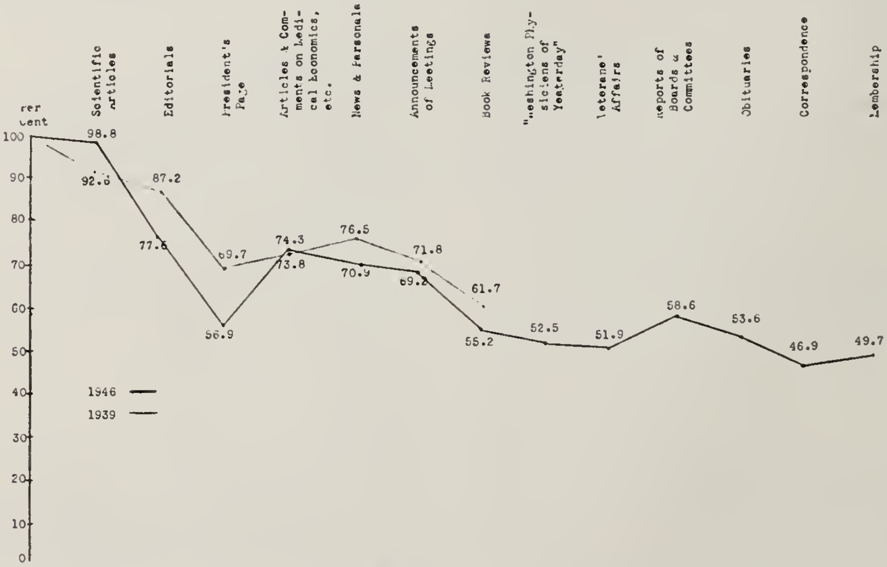
Wholly favorable	63
Suggestions	10
Critical	2
Total	75

Of particular interest were the following—
- Editor should devote some of his time to the preparation of material on hospital problems
- Places where various types of nurses could be obtained should be published
- More conferences and case records should be included
- Why not print proceedings of business meetings of the Society?
- There should be articles on public relations
- An effort should be made to stimulate original scientific work in the District of Columbia
- Devote one issue of the journal to a single field in medicine

An interesting comparison of reader interest in 1939 and 1946 is revealed in the chart appearing below. As will be observed, reader interest in the various departments of the ANNALS, a number of which were not in existence at the earlier date, has not varied greatly.

The Editorial Board proposes to give serious consideration to the recommendations and constructive criticism made by the ANNALS' readers. Certainly, it is significant that most of those who replied want more and better scientific material. None of those who replied and signed their names were unfairly critical. They expressed their opinions frankly as requested. Naturally, the editors are happy that

*Surveys of Reader Interest—Medical Annals of the District of Columbia 1939–1946**



*Surveys limited to members of The Medical Society of the District of Columbia.

the majority of the readers of the ANNALS were satisfied with the Society's publication from the standpoint of content as well as appearance.

MEDICAL BUREAU SERVES BOTH PHYSICIAN AND COMMUNITY

The MEDICAL BUREAU was six years old on the second of December. The sixth birthday of any organization does not in itself occasion anything more than a nod of acknowledgment. Although the work of the BUREAU has not been heralded by the press as a panacea for medical economic problems, it has made some outstanding contributions during its relatively short life. The original purpose of the BUREAU was to aid physicians in the handling of their calls and to make certain information available to the public about physicians and medical facilities. There can be little doubt that the BUREAU has fulfilled these purposes. The scope of operation, however, has not been limited to its original functions. As a matter of fact, it is difficult to determine the limits of BUREAU service and influence. A great deal of its activity has become so well integrated into community life as well as the life of the medical profession that much of its value is really intangible.

For example, it is virtually impossible for any one physician to determine the real worth of the BUREAU. This is true even though he subscribes to the BUREAU and may endeavor to evaluate it on the amount of personal service received. Since the BUREAU is well known as a center for medical information, all physicians, whether subscribers or not, benefit by the service of the MEDICAL BUREAU. Its name has become a by-word among the laity as well as the profession. The need for liaison from the profession to the laity is met, at least in part, by the work of the BUREAU. In this respect, it handles hundreds of miscellaneous calls every week. Their scope is limited only by human imagination.

Since shortly after its inception, the BUREAU has carried out the service of giving to the public the names of physicians by specialty and by locality. The importance of this service cannot be overestimated. It assures the public that they are receiving the names of doctors of medicine and the names of specialists who have had the necessary training to be so classified by the profession itself. Sixty or seventy calls of this type are received daily. It might be said here that it is not infrequent for patients to call back, thanking the BUREAU for helping them locate the right doctor to serve their needs. The classification roster, as it is called, is also used frequently by physicians to locate specialists or neighborhood physicians, whichever the case may be, to whom they may transfer their patients.

For the patient who has no family physician and needs immediate attention, the BUREAU maintains a list of subscribers, known as the emergency call roster, which is composed of physicians willing to accept calls of this nature. The BUREAU has never been known to refuse to send medical aid to anyone genuinely in need of it. This is made possible not only by the physicians participating in the emergency call program, but by the coöperation of the District Health Department and the Central Ambulance Service.

So necessary were the BUREAU functions of locating subscribers, making referrals and dispatching physicians during the War, that the Government furnished personnel to keep the BUREAU in operation. The recognized importance of the BUREAU in the community benefits every practitioner, whether or not he is a BUREAU subscriber.

The vital role which the BUREAU played did not stop with the termination of the War but has continued by lending valuable aid in postwar adjustment. The Medical Bureau Committee has extended to all members of the Society who went into the armed forces, six months' Alternate Listing Service without charge. This is offered by the Medical Bureau Committee as a token of appreciation for the contribution made by those who went on active duty. Through the aforementioned referral system and emergency call program, the BUREAU has aided materially not only many returned Society members, but other veteran-physicians as well, in rëestablishing or establishing their practices.

The success of the BUREAU has been due to the guidance of the Medical Bureau Committee; its very able Chairman, Dr. Joseph Horgan; and the Secretary, Theodore Wiprud. Dr. Horgan, Mr. Wiprud and some of the members have served on the Committee since its inception and have deftly guided it through the illnesses of childhood to its present status of maturity and position in the community.

Those connected with the BUREAU continue to make plans for its greater service to the laity, the medical profession and particularly to its subscribers. There are many requests for direct line service, which is known as Telephone Secretarial Service. Plans are going forward with The Chesapeake and Potomac Telephone Company for the additional equipment which is necessary for extension of service to all who desire it. As everyone knows, because of the War and labor disputes, it has been virtually impossible to secure the highly specialized telephonic equipment of the type needed by the BUREAU. Every effort is being put forth to expedite procurement of equipment and it is hoped that within a few months Telephone Secretarial Service will be available to all physicians upon their request.

J. RICHARD CONNELLY
Manager, Medical Bureau

In and Out of Focus

BY THE OBSERVER

Membership Largest in Society's History

Any regular attendant at medical conventions will tell you that he gets more out of private conversations with those with whom he has interests in common than he does from the formal program. Such discussions usually develop information which is of real value to him. He is afforded an opportunity, too, of comparing his progress with those of others in like pursuits.

One thing your Observer learned in conversations with a number of other medical society officials at the recent AMA meeting was that medical societies throughout the country are flourishing. Membership rolls have reached an all-time high, nearly all physician-veterans having returned to their communities or established themselves elsewhere. This growth, of course, is not due alone to the resumption of civilian practice by veterans. There are thousands of physician-veterans, graduated from medical schools during the War, who had never been in practice and who are now opening offices.

Increase in the membership of the Medical Society of the District of Columbia has been unusually great. The most recent figures available to your Observer indicate that at the end of 1946 the membership will reach 1,344, an increase of 109 over December 31, 1945. Of these, 1,106 will be Active and Life members, 227

Associate members, and 11 Honorary members. An additional 160 applicants for Active and Associate membership have been recommended for election early in 1947 by the Board of Censors, which will increase the total membership to 1,504.

The population of the District at the present time is about 930,000. The ratio of Life and Active members, most of whom are in private practice, as compared to the population, is, therefore, approximately one physician to every 775 persons. However, one cannot accept this ratio at its face value for a number of reasons. To begin with, the above figures do not include all practitioners in the District. Then, too, there are a considerable number of licensed physicians who, because of advanced years or poor health, are incapable of carrying on practices. Their exact number is not known. Another factor which remains to be established is the extent to which the population of Montgomery and Prince Georges Counties, Maryland, and Arlington and Fairfax Counties, Virginia, and the City of Alexandria, all within the Washington metropolitan area, rely on District physicians for specialist care. So an adequate evaluation of the situation would require an exhaustive survey such as was conducted two or three times during the War by the District Procurement and Assignment Service, the United States Public Health Service, and the Society.

In view of these circumstances, no one can state definitely how adequately Washington is supplied with physicians. Some physicians have inquired at the Society's office about the opportunity for specialists. Approximately 915 members of the Society have been classified according to type of practice by the Classification Committee with the following results:

Allergy	8	
Anesthesia	26	
Dermatology	21	
Internal Medicine	140	
Otology-Laryngology-Rhinology	60	
Ophthalmology	32	
Obstetrics and Gynecology	80	
Orthopedic Surgery	21	
Clinical Pathology	11	
Pediatrics	54	
Physical Therapy	3	
Plastic Surgery	6	
Proctology	4	
Psychiatry (Neurology)	34	
Neurosurgery	3	
Radiology-Roentgenology	16	
Surgery	92	
Tuberculosis	10	
Urology	27	
Syphilology	4	652
General Practice		
N. W. District	191	
N. E. "	42	
S. E. "	27	
S. W. "	3	263
TOTAL		915

It must be kept in mind that about 200 to 300 Active members have not sent in their classification forms. However, a majority of specialists have been classified, and the above figures should indicate whether there is a surplus of specialists in a certain field. But conclusions with respect to any specialty, your Observer hastily relinquishes to the reader. He has his opinions, of course, but they are only opinions and he will keep them to himself.

What significance does its growth have for the Medical Society itself? It is your Observer's belief that it has gained much in vigor because a majority of the new members are young, enthusiastic, and capable. Incidentally, they have shown much interest in the Society. Wherever possible, therefore, they should be given an opportunity to serve the Society according to their interests and capabilities.

To the Society's office personnel, the increase in membership means an expanded program which will entail greater responsibilities and considerably more work. The Society has carried on for years with a limited staff. It must now employ sufficient help if it is to render satisfactory service.

Members of the Medical Society can be assured that paralleling the Society's rapid growth will be a much more ambitious and effective program. Officers are determined that the Society shall maintain its important position not only in Washington but in the Nation.

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Times Have Changed

All those in attendance at sessions of the AMA's House of Delegates in December must have noted the seriousness of participants. There was not the usual display of lightheartedness which characterizes gatherings of this kind. This was particularly true of the delegates, who seemed only too well aware that organized medicine is passing through a critical period.

Although the complexion of the House hasn't changed a great deal, it is evident that the thinking of its members has, where medical socioeconomic matters are concerned. Whether the more liberal policies adopted were wholeheartedly endorsed in the beginning, it seemed to your Observer that the acceptance of them was now about complete. No longer did one have the feeling that oldsters who still are the leaders in the House were uttering words contrary to their convictions. They now spoke of changes decided upon by the House as being not only necessary but desirable. This was most noticeable in their discussions of prepaid medicine. Here there was no hedging, no suggestion that action be delayed, nor was there a dissenting voice regarding the program now in the making. There was a job to be done, and all wanted to be of help.

The importance of good public relations has long been accepted by physicians. But there have been divergent opinions as to methods. Some believed the solution lay in the employment of lay experts in this field. This view is now apparently fully accepted by the House, marking a decided departure from its former attitude. How much the widely publicized Rich report had to do with this, your Observer does not know. However, there is no doubt that the report made a deep impression on the delegates. As this report was considered in executive session, it is not possible to report details here. However, if its recommendations are carried out, the AMA will be a much more efficient organization than it is at present, especially from the standpoint of public relations. Laymen, too, will play a much more dominant role in some of the AMA's activities.

Representatives of the National Physicians' Committee were much in evidence However, there seemed to be less enthusiasm for the Committee than heretofore. It is true that most of the delegates and many other officials of state and county medical organizations attended a dinner given by the Committee as its guests. But it was quite evident that relations of NPC and AMA will not be as intimate as they have been in the past. The attitude of our Society toward the Committee has been stated a number of times. It has not endorsed NPC, nor is there any present prospect of its so doing. The position taken has been that there is nothing that NPC does that the AMA is not in a position to do far better.

All in all, your Observer, was well satisfied with this meeting of the House. He feels certain this was true of other representatives of the Society present, Dr. Coursen B. Conklin, the Society's delegate, and Dr. Herbert P. Ramsey, delegate-elect. There were things done that might well have been left undone. But the impression as a whole was that of a body of physicians anxious and willing to cope in a realistic manner with the issues before them.

★

Veterans' Agreement Signed

A conversation which your Observer had a few weeks ago with a state medical society official in Chicago led him to conclude that although agreements with the Veterans Administration providing for the treatment of veterans by private physicians have been entered into by most states, demands for physicians' services under these agreements vary considerably in different parts of the country. In some sections, private practitioners provide most of the care; in others they have very little to do. This is not surprising in view of the fact it was understood that where administration facilities are available, they will be used by veterans. When these are no longer adequate, veterans will be referred to private physicians.

No physician in the District of Columbia, your Observer is informed, has rendered medical service to a veteran in his office. However, our Society was the first to inform Dr. Paul R. Hawley, Medical Director of the Administration, of its wish to coöperate in every way possible. Because there were more facilities in the District for the care of veterans than in any other community, the Society's was the last agreement entered into by the Administration with a medical organization, signatures to the document being affixed by Government officials November 15, 1946.

Members who did not attend the special meeting of the Society held on October 23, 1946, may be interested in some of the more important provisions of the agreement. First of all, the Society promises to urge all of its members to participate and to furnish the best possible medical care to veterans. Physicians who agree to participate will be appointed "fee designated physicians of the Veterans Administration." Any physician who accepts such an appointment can resign at any time. A fee schedule is made a part of the contract, the physician, being paid directly for his services by the Administration. The schedule will be adhered to except in "unusually involved cases and services not scheduled." The latter will be subject to review by the Society. Recommendation will be made to the Administration as to the appropriate fee. The Society also agrees to assist the Administration "in establishing examinations for specialists." All administrative clerical details will be handled by the Administration. Treatment of any veteran by a private physician must be authorized by the Administration, the veteran being given an opportunity to select from the Society's list his own physician. Reports of examinations and services rendered will be required. No fees will be paid until the reports acceptable to the Administration are received. The Society agrees to appoint a committee of physicians to act as a board of review. The board in the District will be the Society's Committee on Medical Care for Veterans.

Before these lines appear, members will have received a communication from the Committee enclosing the approved fee schedule, together with a form on which to indicate their wish to participate. Although it is not anticipated that private physicians in the District of Columbia will render services under the agreement in the very near future, the time may come when the number of veterans in need of medical service will increase to the point where the private physician's services will be in demand. It is not improbable that veterans may be furnished medical service for nonservice-connected disabilities. One must also take into account the possibility, however remote, that dependents may become eligible for medical care.

The Committee is counting on the participation in this program of all Society members in active practice, and prompt response to its communication is expected.

★

Fads and Physicians

The gullibility of people generally where their health is concerned is often a source of wonderment to physicians. Individuals who one would think would know better are frequently, to put it politely, uninformed. It is difficult to understand why the educated and even intellectuals believe the silliest sort of nonsense about their health. They are superstitious, too, and accept long-discarded theories without question.

Most physicians find these shortcomings of supposedly intelligent and trained men and women amusing. However, they, too, in their own way, are not free from ignorance where acceptance of unproved and discredited remedies are concerned. Your Observer has been around medicine long enough to discover that doctors enthuse extravagantly over forms of treatment which are later determined to have limited value.

Medical history abounds with examples of physicians waxing enthusiastic over newly discovered remedies and prescribing them indiscriminately for all sorts of ailments. Within your Observer's recollection, physiotherapy was thus abused. For example, high frequency diathermy apparatus, under the stimulus of high pressure salesmen, was sold to thousands of physicians in the nineteen twenties. In their enthusiasm, physicians used it for everything from a backache to migraine. Later, this equipment was entirely discarded for the short wave diathermy apparatus. The use of this, too, was overdone. Eventually, its limited value as a therapeutic agent was determined.

More recently, the various sulfa drugs were prescribed for every conceivable ailment. Physicians soon learned that not only was this drug of little value in the treatment of many diseases, but it was also dangerous if improperly used. Now that these valuable drugs have been properly evaluated, they need no longer be dangerous, and within certain limits have a definite value.

Then, of course, there are the vitamins, which are not only prescribed by physicians, but sold directly to the public in vast quantities. Admittedly, the physician is not to blame for what Brigadier General Wallace H. Graham, the President's physician, recently calls the "vitamin craze." In an address before the American College of Surgeons, General Graham warned that excess dosages of vitamin D might calcify kidney tissues, heart muscles, and even involve the lungs, stomach and blood vessels, causing death. While physicians decry the "vitamin craze," there is still apparently too much prescribing of vitamins. Gradually, vitamins will find their proper place in the physician's armamentarium.

There is no question as to the efficacy of penicillin, but in the first flush of enthusiasm, it, too, has been used in diseases where it has had little value. One hears frequently of physicians prescribing it in desperation when other remedies are of no avail. The same has been true of streptomycin.

Surprisingly, there are also some discredited as well as accepted drugs being improperly prescribed by physicians. The editor of *Philadelphia Medicine* for December 7 decries this practice in the following words:

> "Possibly enough syrup of hypophosphites as a 'tonic' has been prescribed to fill Lake Erie even though it has been shown time and again that virtually all of it is eliminated from the body unchanged. Boric acid in solution and in ointment has been for ages and still is a therapeutic standby even though we all know the drug has practically no antibacterial action and is a poison which has caused death in ointment applications and following other therapeutic administration. Digitalis is another drug which has been misued dreadfully simply because it has become a habit to prescribe it for every patient with a heart murmur, whether there is any indication for it or not. Again, though possibly through mental laziness rather than habit, many physicians continue to prescribe the sulfa drugs where experience has proven them useless or even contraindicated, as, for instance, in the common cold."

So, it would appear that while it is our responsibility to enlighten the gullible public in matters of health, we have an educational job to do inside our own profession.

★

Dodging the Issue

There have been times when your Observer has felt he has been too critical and that this column has been filled with laments about the shortcomings of groups and individuals. Readers, it has seemed to him, must get weary of his recital of the deficiencies of organized medicine. After all, what can they do about it?

Your Observer has the answer to that one. The power of medical opinion, i.e., the rank-and-file of the profession, is far greater than physicians generally realize. As to criticism, it has always been your Observer's opinion that if it is of a constructive nature, nothing but good can result. That he is one of the milder critics of organized medicine is illustrated by an editorial in the December 16 number of *The Detroit Medical News*. It is signed by Dr. Frank A. Weiser, Associate Editor of the *News*, and is entitled "No Pipsqueak Need Apply."

In his opening statement, Dr. Weiser says that social change is in the making, and will of necessity involve the medical profession. Then he hauls off with this one, "To date the profession has done little more than dodge the issue with a laissez faire philosophy." He insists that most physicians would not wish labor to "lose the social advantages it has gained for itself," but that labor unions should be made more responsible. Then he goes on to say:

> "We feel sure that some kind of medical care clause will be enacted in the labor-management contracts of the future. It is our duty as citizens to give without bias, as far as is humanly possible, of our advice and knowledge in the planning of the health and welfare of our people under these contracts, but we can't do that until we get off our high horse of sensitivity to criticism. We have missed our big opportunity up to the present because we do not understand the public viewpoint, and the public has become suspicious of our reasons for fighting off political medicine because the public does not understand our viewpoint.
>
> "We have forced each other unwittingly into noisy debate with all of its emotionalism, accusations and disorderly thinking. We could if we had the proper advice, and God knows we need it, make a further contribution to the happines of American mankind.
>
> "We have tried to influence public opinion by ineffective, disconnected, unorganized propaganda efforts. The AMA, National Physicians' Committee, and the state and county medical societies have all taken a stab at it. Our own local and state effort has consisted chiefly of a type of radio program that is denounced as worthless by experts in the radio programming field—in pamphleteering an already overpamphleteered public and other pusillanimous gestures."

What solution does he have to offer for this sad state of affairs?

> "We believe our entire public relations program should be scrapped now—" Dr. Weiser says, "not next month or next year, and in its place we should secure a forthright critical lay person of stature to act as counsellor to the medical profession. The pharmacists, dentists and physicians of the Great Lakes area, through their respective state societies, could combine into one region or district to provide the necessary funds. We have in mind someone of the calibre, experience and stature of Senator LaFollette, who has been in public service for many years and who has demonstrated his liberalism, his integrity and his courage.
>
> "No pipsqueak will suffice."

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Is This Good Public Relations? The hour was late and the delegates weary after an all-day session when the following resolution came before the AMA's House of Delegates at its December meeting:

> "WHEREAS, The United States Public Health Service was created, organized and is amply financed for certain specific purposes, namely the promotion of the public health, the prevention of disease, the control of epidemics and the extension of help and advice to state and local communities in these and similar problems of disease prevention; and
>
> "WHEREAS, The United States Public Health Service in wartime has certain additional duties and functions related to the armed forces in assisting them in protection of the nation and its citizens; and
>
> "WHEREAS, Existing federal laws contemplate that regular officers of the United States Public Health Service shall devote their full time to the aforementioned duties; and
>
> "WHEREAS, Certain officers and members of the United States Public Health Service, including its Surgeon General, have within the last year so put aside consideration of the functions and duties for which they were appointed and commissioned as to devote much of their time and energy to political activities, even to the extent that the Surgeon General of that service has issued written orders to his staff and his officers directing their

> utterances and thinking on highly controversial questions of medical legislation wholly unrelated to the proper functions of the United States Public Health Service and in opposition to American democratic processes; now therefore be it
>
> "*Resolved*, That the House of Delegates of the American Medical Association condemns without qualification, as a perversion of function and dereliction of duty, political and partisan activities on the part of officers of the United States Public Health Service, including its Surgeon General, and recommends that steps be taken to prohibit political activity on the part of the United States Public Health Service, and that further steps be taken to restore the prestige of this important department of our government in the scientific field for which it was created, organized and financed."

Up rose Dr. James A. Crabtree, Deputy Surgeon General, to defend his chief. Dr. Crabtree said that Dr. Parran was duty bound, in view of his position, to espouse President Truman's views on health. However, when he was finished, he was severely taken to task by several speakers, who eloquently supported the resolution. Unfortunately, your Observer was not present to hear the arguments, but this is essentially what happened.

As might have been expected, Dr. Parran had many defenders. There were those who resented the AMA's criticism of Dr. Parran, because of his splendid record as a public health administrator. Mrs. Eleanor Roosevelt was one of the first to rally to his defense. In her daily newspaper column, "My Day," she wrote:

> "I was shocked the other day to read of the attack on Surgeon General Thomas Parran by the American Medical Association.
>
> "The Surgeon General of the U. S., it seems to me, has a perfect right to advocate the President's health program if he approves of it. Health is not a thing based on partisan politics, and public health should not be regarded, either by officials in Washington or by doctors, as a political football.
>
> "There are differences today within the medical profession as to how more medical care should be made available to the average individual with a small income. As far as I know, there are a considerable number of coöperative hospital plans and a growing number of medical plans on an insurance or coöperative basis.
>
> "The American Medical Association, for reasons best known to its own leaders, but which sometimes seem somewhat selfish to the layman, has decided to oppose most of these plans and it dislikes particularly the Wagner-Murray-Dingell bill. I am only a layman and I don't imagine that this bill is the last word, or the best health program that will ever be developed. But it is a step in the right direction—and we seem to forget that democracy functions by taking one step at a time. As more people become convinced of the value of something, it becomes more universally accepted. Democracies move slowly because they envision the approval of a majority for any new policy, and that means much education of many individuals.
>
> "I believe medical men, above any other group in this country, should refrain from attacking as good a public servant as Dr. Parran has proved himself to be just because they happen to differ on methods by which medical care shall be provided for a great number of people. No one denies the existence of the need, and we can argue out the methods without feeling that people advocating any particular methods have no right to their point of view. The majority will decide in the long run."

As is well known, Mrs. Roosevelt has never been friendly to organized medicine. That she has had no change of heart is shown by the above statement. Commenting on the "growing number of medical plans on an insurance and coöperative basis," she observes that the AMA "for reasons best known to its own leaders, but which sometimes seem somewhat selfish to laymen, has decided to oppose most of these plans." Mrs. Roosevelt undoubtedly has in mind the plans which she particularly favors. However, she is unfair if she intended to imply that the AMA is generally opposed to the voluntary sickness insurance plans.

Whatever one may think of Mrs. Roosevelt's column as a literary effort, it is widely read. In fact, a survey recently completed by the Publication Research Service of Chicago reveals that she leads all columnists—men and women—in women reader interest. Now, she was only one of the vocal and widely-publicized individuals who criticized the AMA for its action. There were others who always delight in taking a swing at organized medicine. Regardless, therefore, of the merits of the resolution condemning Dr. Parran, the House's action certainly did not constitute good public relations.

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"Superfluous Attachés"

Having written thousands of words on many different subjects, it would be surprising if your Observer did not repeat himself. It runs in his mind that he has previously had something to say about frequent complaints of younger physicians that older practitioners run medical society affairs. Your Observer has heard this countless times, and in all fairness it must be said that in a large measure it is true. But the fact that it is true does not necessarily mean that it is undesirable, that is, unless the organization is dominated by conservative "elder statesmen" whose purpose is to maintain the status quo. Younger men should remember that men of the same age vary widely in their points of view. As stated in this column last month, there is also considerable difference between an individual's chronological and biological age. Many men of advanced years retain their youthful outlook, while others go to seed in early maturity.

What has been said has reference primarily to younger physicians in practice. What about the intern? Has he any just complaints? One doesn't hear from him so often, but recently a physician spoke up in his behalf. In a letter addressed to the editor of *The New England Journal of Medicine* for November 28, Lieutenant J. DeWitt Fox of the Medical Corps of the Army of the United States, writes:

> "Everyone concerned in the patient-doctor-hospital relation stands to gain by a more cordial affinity between staff physician and intern. The visiting physician seems to have become inured to the lowly intern as an ornate figure in white that the hospital has hired and stationed as silent sentry. Instead of taking full advantage of an enthusiastic scholar fresh from the portals of medical learning, the intern is by-passed in the doctor's care of private patients and completely deleted from their management. Both are the losers in such an aloof and lowly arrangement. Hence, the intern's year often passes without the establishment of close contact with the physician, for which he yearns and is justly entitled. He is allowed to pursue his tenure in white as a superlative and superfluous hospital attaché, who must of necessity be allowed to complete his requirements for licensure."

Throughout a rather lengthy communication, Lieutenant Fox emphasizes the adverse conditions under which the intern often labors due to lack of understanding upon the part of his seniors and of opportunities afforded him to improve his lot.

> "A pet peeve of the junior man in the operating room," he says, "is the 'eager beaver' surgeon—the one in such a mad rush to earn his first million dollars that he never allows the intern to do anything but hold retractors or get out of his way. If the surgeon believes that the preoperative and postoperative care of his patients is sometimes not just what it ought to be, perhaps there is a reason. If he permits the intern to consider himself an integral part of the surgical team, not an ornament or a modified scrub nurse, he will soon note remarkable improvement in the intern's interest in the postoperative course of patients."
>
> "The intern does not ask for the surgeon's knife, but merely for an opportunity to learn a little surgical technic and the privilege to get the feel of things at the operating table—the chance of tying a few knots, snapping on hemostats, closing skin incisions and performing minor procedures under supervision. Such small gestures of confidence in the intern do take a little extra time on the part of the surgeon. But the time is well invested. It will pay big dividends in the care of surgical patients."

The *Journal* turns a sympathetic ear to Lieutenant DeWitt's views, stating its opinion as follows:

> "It is surprising to learn that there are presumably up-to-date hospitals anywhere in the country that can pretend to function properly with their interns marking time as superfluous attachés. We hope that there are fewer in existence than our informant believes, and that there are not many practitioners of medicine or surgery who dare to assume full responsibility for hospitalized patients without the complete coöperation of an efficient resident staff. It had not occurred to us that such teamwork could be lacking anywhere to any appreciable extent.
>
> "There was formerly an era in which the bulk of

medical knowledge was in the possession of the practitioner, who, according to his characteristics, was gracious or otherwise to his hospital interns. Today the shoe comes closer to fitting the other foot: it is the uncoöperative attending physician who runs the risk of being by-passed by his house staff if he does not recognize and appreciate the services that are usually available to him and can hardly be obtained otherwise."

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A Lost Art?

On a number of occasions, your Observer has expressed his concern because of the high-pressure existence of physicians. He has at various times commented on the excessive demands made upon their time—that there were too many organizations and consequently too many meetings for their physical and mental wellbeing. On occasion, he has presented facts which would lead one to conclude that because of their strenuous régime, their life expectancy is below average. He has urged the need for proper rest, relaxation, and time for reflection, in other words, an existence in which there is joy in living.

That there are others concerned with this matter is evident from editorial comments in medical journals which have come to your Observer's desk in the past month. For example, the *New York State Journal of Medicine* for November 15 concurred with a New York columnist that with most of us "being too busy is a bad habit, largely traceable to giving too much thought for the morrow." This applies, the *Journal* observes, with equal force to doctors.

> "A continuous round of house and office visits, of operations, of attendance at medical meetings, and of other duties, should be interrupted during the day by a period of 'doing nothing,' when the mind can be at rest or occupied with something that has no connection with medicine itself. A good book, a nap after lunch, playing with a hobby, reading a nonmedical book or magazine, even the day's news, offer that opportunity for relaxation which is not only of immediate benefit but of value in the future.
>
> "This is not to be lazy or idle, it is the part of wisdom to be able to idle successfully and not be bored by it. We physicians should urge ourselves to do more of it for our own good as well as that of our patients. By so doing, the doctor might achieve the happy objective advocated by Mark Twain when he remarked of Henry Ward Beecher that 'he is now fast rising from affluence to poverty.' "

The editor of the *Jackson County* (Kansas City, Missouri) *Medical Society Weekly Bulletin*, in the December 7 issue of his publication, also has something to say on the subject.

> "In this age of speed-worship there appears to be increasingly less time for thought and contemplation. Even for those who have some slight desire to sit alone and ponder over any given situation, there can be but slight opportunity under present circumstances."

In his usual forthright manner, he elaborates on how some have sought havens for contemplation. Among those suggested are the "lavatory" and horse-and-buggy conveyances. But he says these suggestions lead only to "some sort of mental cul-de-sac such as: Why worry about thinking and contemplation, what good will that do anyhow?"

Despite this conclusion, he believes we should seek by one means or another "to rescue the almost lost art of contemplation."

If the reader expects your Observer to conclude these comments with evidence to prove that the physician's turbulent existence results in his early demise, he is in for a surprise. Your Observer had long been under the impression that the mortality among physicians in early middle years was higher than for the general population. However, Dr. T. R. VanDellen, in his syndicated health column, assures us that physicians do not die any younger than anyone else.

> "In 1945," he says, "their average age at death was 65.3, compared with 64.9 among the millions of industrial policyholders of the Metropolitan Life Insurance Company.
>
> "Of the 4,015 physician mortalities last year, statistical data are available on 2,962. Only 441 were between the ages of 25 and 49, whereas 1,311 were over 70. Three lived beyond the century mark. As with the general population, heart trouble took the greatest toll. Cancer and tumors accounted for 296 and 145 had pneumonia. From there on, examples of almost any disorder

can be found, demonstrating that the medical profession is no more immune to various ailments than any one else."

So, it would seem that despite the pressure under which they labor, physicians are not paying a high price for it physically. Nevertheless, one cannot but conclude that they miss much of the pleasure of living which comes from time for reflection and relaxation.

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Are Good Doctors Scarce?

One hears frequently that patients are incapable of choosing a good physician for the lack of reliable information. This, it is said, is particularly true in large cities. Call medical societies, and all you get is the names of three or four physicians from which you select one. There is no assurance that the practitioner you choose is qualified in his field, nor are there satisfactory means of determining his ability. This situation is especially serious because an estimated fifty per cent of the medical profession is incompetent. Something should, therefore, be done about this state of affairs without delay, says Greer Williams in an article appearing in the December 21, 1946 issue of the *Saturday Evening Post*, entitled "Good Doctors Are Hard to Find."

Mr. Williams, your Observer believes, has endeavored to present an objective picture. However, he reveals his bias when he says:

> "The AMA sets the standards for the medical profession and, if you follow its suggestion, you'll call the county or state medical society for an opinion. It will give you the names of three or four physicians or tell you whether anyone you name is recommended. Any doctor is recommended if he's a member of a medical society affiliated with the AMA. He is, as they say, 'recognized' or 'reputable.'
>
> "All this is to the good, and at least saves you from outright frauds. Perhaps you recognize, however, that it is a rubber-stamp qualification. Furthermore, you may feel that the medical societies have depreciated the value of AMA approval by using it as an economic weapon against doctors who went in for group medicine. I know of a number of doctors and clinics who fell from grace for engaging in low-cost, nonprofit group practice that happened to offer better-than-average care to the patients. Claiming it was unfair competition for solo practitioners, many a medical society boycotted group doctors. The United States Supreme Court finally held that this was a restraint of the patients' right to trade, and the AMA itself now sponsors prepaid group medical plans."

If Mr. Williams were objective, he would not have dragged in the group medicine matter. It has been a dead issue for a number of years. Certainly this is true in Washington, where the frequently referred to anti-trust suit was tried. Mention of it serves no good purpose, nor does it strengthen Mr. Williams' arguments with those who are familiar with the medical situation.

Soundly enough, Mr. Williams warns the public against relying upon the advice of lay persons and what he calls hearsay judgment. However, on the basis of discussions with physicians, he would "discount" the services of 50 per cent of the medical profession. In other words, one-half of the doctors in this country, he suggests, are incompetent. This just isn't true, regardless of the medical sources from which he says he obtained his information. That many poor doctors just couldn't make the grade in modern medical schools.

Formal standards, Mr. Williams observes, are not infallible guides. It is true that many competent physicians have not passed specialty boards. Mr. Williams mentions specifically the American Board of Surgery. There are outstanding surgeons, some here in Washington, who have not passed this Board principally because of their age when the Board came into existence and the fact that they were well established, and had no need for its stamp of approval.

Mr. Williams suggests in "choosing the right doctor," to size up the doctor and his environment. Personally, he says, he endeavors to find a doctor's doctor. He feels that in such selection lies the greatest safety. He admits, "The AMA has done a thorough job of educating the public on the marvels of medical science, but, unfortunately, neglects to say just where these marvels are being dispensed. Actually, when it speaks of America having the highest quality of medical care, the AMA is speaking of the top-grade doctors only."

> "The power of the AMA over each medical society and each member is in reality quite limited, but it is in the paradoxical position of setting high standards and endorsing physicians who fall short of them. Organized medicine tries to drive out the obvious quacks, but closes its ranks to protect its weaker brethren from public scrutiny."
>
> "Our willingness to stick with the present system to date, despite its acknowledged failings, stands as a challenge to the medical rulers to lead us to the high-quality care they talk about. Every doctor with whom I discussed the problem of choosing a physician welcomes the challenge. They were the best, but the best they could offer, except for a few good tips requiring the patient to be the judge, was little more than trial and error."

There is no denying the fact that one of the medical profession's greatest responsibilities is the protection of the public against incompetent physicians. Obviously, this can only be accomplished through a more careful selection and better training of medical students. However, we have already come a long way in this respect, the quality of medical graduates having steadily improved in the last dozen or more years. Educational standards are ever rising, and fewer physicians are entering specialties without being qualified by a specialty board.

To bring the matter directly home, what is the situation in Washington? We believe that patients in the Nation's Capital choose doctors with greater safety than in any other city in the country. As Society members know, the public has available to it through the Society's telephone exchange, MEDICAL BUREAU, a list of physicians, classified according to type of practice. This list was prepared under the supervision of the Classification Committee, on which nearly all specialties are represented. Each classification form filled out by the physician is reviewed by the Committee, and approved by the member in the specialty to which it pertains. Thus, the information given out by the BUREAU with regard to physicians is as reliable as it can be made.

Every physician classified is qualified to do what he claims to be able to do. At least, he is so qualified by medical staffs of class A hospitals. Regardless of qualifications, as Mr. Williams properly points out, capabilities of physicians vary. Some of the best trained physicians are not the most expert, and vice versa. Generally speaking, however, excellent training counts heavily in the physician's favor.

Your Observer believes that the Medical Society of the District of Columbia has rendered a public service which might well serve as a guide for other medical organizations, especially in large cities. There would then be less reason for complaints such as Mr. Williams lodges against organized medicine.

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"Editing Remains an Art—"

At the recent Conference of State Secretaries and Editors held in Chicago, your Observer addressed editors of state medical journals on the subject, "The Medical Editor Consults His Readers." In the course of his discussion, he reported efforts made by the editors of the MEDICAL ANNALS to determine reader interest and to obtain suggestions for improving the Society's journal. Results of this investigation are published elsewhere in this issue of the ANNALS.

By coincidence, on the same day that the talk was given, there appeared an editorial in the *Chicago Daily News* entitled "Editing Remains an Art Despite Readership Guide." The *News* stated that a series of studies of reader interest covering a seven-year period had been undertaken in 1939 by the Bureau of Advertising of the American Publishers' Association. Its purpose, according to the editorial, was "to determine factually and without bias the degree of attention which readers give to the content of American newspapers."

Only two questions were asked by the carefully trained field workers, who were assigned to certain sections of each city, "Did you happen to see or read anything on this page?" and "Did you happen to see or read any of the advertisements on this page?"

It has long been taken for granted in the newspaper world that "nobody reads the editorials." These studies proved the contrary was true. According to the *News*, "the percentage who read editorials ranged from 77 to 17 with a median of 45. For the women, the median percentage was 29."

There followed ratings of the various departments, such as news photos (very high), editorial cartoons, political columns, panel oddities, comics, weather, and so on.

The point in mentioning this survey is not to make any comparisons with the very modest investigation made by the editors of the MEDICAL ANNALS, but to point out the different approach necessary in determining reader interest in state medical journals. Editors of newspapers and lay periodicals can, to a large extent, gauge the satisfaction of their readers by circulation figures. State medical journals, on the other hand, are mailed without charge to all members. Whatever cost there is, and it is very small, advertisers footing most of the bill, is included in their dues. Obviously, therefore, reader interest in these journals cannot be judged by their circulation, and the questionnaire or sampling method must be used. But readers' opinions, the *News* points out, should not be considered the sole criterion of the adequacy of a publication.

"The stature of a great newspaper in its own community, its reputation for accuracy and fair dealing, the intangibles that have accrued to it through the peculiar genius of many reporters, editors and publishers—these are the qualities that are never brought to light in a scientific survey."

The conclusion "that it would be possible to edit a first-rate newspaper along purely scientific lines," the *News* concludes, is, therefore, not justified.

This is something for the medical editor to remember. While the satisfaction of at least a majority of his readers is vitally important, he must satisfy his own critical judgment that he has produced the best of which he is capable.

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Footnotes When your Observer prepared his comments on the World Medical Association for the December number of the MEDICAL ANNALS, he did not know that the AMA's Board of Trustees had voted that the Association should become a member of WMA. Affiliation with WMA was announced in the October 26 issue of the *Journal of the AMA*. The AMA will be entitled to two seats in the governing body. . . . According to press reports, the United States Public Health Service will ask the next Congress for funds to build what is described as a multimillion dollar medical research center at Bethesda. Plans include a 200-bed hospital for cancer patients, another hospital of about the same size for patients with heart conditions and the aged. Five to ten millions are being sought for cancer research for the year 1948, including funds for research by universities, hospitals and individuals. . . . Dr. Martha Eliot, Assistant Chief of the Children's Bureau, in charge of Maternal and Child Health Services, is optimistic about the future. According to *The New York Times*, Dr. Eliot, who is also President-elect of the American Public Health Association, "discounted widely voiced beliefs that a Republican Congress would not appropriate for health and welfare purposes." Among those on whom she counted for assistance is Senator Robert A. Taft, who she said had joined with Senator Pepper of Florida in introducing a "bill which when approved doubled state grants for maternal and child health, crippled children and child welfare programs.". . . . President

(Continued on page 55)

The Editors' Forum

THE WILL TO SERVE

Stanley B. Weld, M.D.
Editor, Connecticut State Medical Journal

Editor's Note: This is the second in a series of articles written especially for this department of the Medical Annals by outstanding medical editors.

Although Dr. Weld's journal is comparatively new, having just celebrated its tenth anniversary, it is an exceedingly attractive and well edited publication. Those who are privileged to know Dr. Weld personally rate him highly as a physician, editor, and a man. His ability, sincerity and integrity have won him many friends. Needless to say, he is highly respected by physicians not only in Connecticut but throughout the country.

The voice of the President of the University of Chicago is one among many raised in warning of the dangers of too much leisure. Our distinctly American institution, the long weekend, plus the shortened working week have added to the leisure time of both laborer and capitalist with the result that more time has been spent in the whirl of pleasure-seeking and less thought or inclination in service to their fellow beings. The Editor of the *New York State Journal of Medicine* states that "something is fundamentally wrong when large aggregations of people cease productive work in a time when the public health is at top levels." This trend has been attributed to the mistaken paternal benevolence in Washington and, if continued, might be one of the most potent factors in bringing about a new era in which federalized medicine will be a reality rather than a mere threat on the horizon.

The changing trend away from service to leisure is seriously affecting the professions. The shortage of nurses has become more acute during the postwar period than at any time during the War itself. Leaders in that profession attribute as a cause the unwillingness of many nurses to serve unless compensated on a par equal to labor. Physicians returning from the armed forces have been reluctant to resume their prewar schedule of irregular hours and uncertain remuneration. Some have preferred to accept a salaried position with a corporation or remain in the employ of the Federal Government.

The day of the horse-and-buggy doctor has disappeared, but with him have gone many of those attributes which distinguished him from his neighbor and gained for him admiration as well as prestige among his fellow townsmen.

In the capacity of advisor to the young man contemplating the practice of medicine we should emphasize first of all the importance of the attitude of service. This should supersede all other motives in his choice, not overlooking the importance of a strong appeal which medicine itself creates. In all the changing social order which is taking place in the world today the physician above all others will remain its most outstanding altruist. The true yardstick of success in the medical profession must be the will to serve. The poet has interpreted our Hippocratic Oath in these words:

"A poor man served by thee
shall make thee rich;

A sick man helped by thee
shall make thee strong;

Thou shalt be served thyself
by every sense

Of service which thou renderest."

REPORT OF THE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

In the short period of three days, December 9 to 11, 1946, 166 delegates and alternate delegates to the AMA's House of Delegates were made aware of activities vitally affecting the welfare of the public and some 130,000 physicians on the Association's membership roll.

In conformity with the action taken in San Francisco, many resolutions coming up for consideration and a vote had already been published in the *Journal of the AMA*. Nevertheless mimeographed copies were placed in the hands of delegates at the beginning of the session. Resolutions from the floor were not precluded because they had not been published.

As instructed by the Society, your delegate introduced a resolution urging closer coöperation with the American Dental Association and recommending the appointment of a committee of five physicians to meet with a similar committee of ADA. This resolution was among those not prepared in time for previous publication in the *Journal of the AMA*. However, it was received favorably by a reference committee and ordered by the House of Delegates to be referred to the Board of Trustees for the accomplishment of its purpose.

Obviously a report of this character cannot include as much detail as would seem important. Our membership is therefore urged to read the transactions of the House which will appear serially in the *Journal* in December, 1946 and January, 1947.

Of special interest to delegates was the increase in the AMA membership, above all the increase in fellowships. In the first 11 months, 3,986 new Fellows were elected making the total number of Fellows 71,553. It is recommended that members of The Medical Society of the District of Columbia check with the Secretary, and if not now Fellows take the simple steps necessary for attaining this distinction.

Prepayment Plans

There are now but two states without prepayment plans in some stage of development. Eighty plans are now operating in 33 states and Hawaii and Puerto Rico. Five of them have an enrollment of more than 250,000.

Attention of our members is called to the brochure, "Voluntary Health Insurance vs. Compulsory Sickness Insurance" prepared by the Council on Medical Service of the AMA; also to "Check and Double Check on Sickness Insurance" published by the Public Relations Bureau of the Medical Society of the State of New York. The latter is designed for laymen and is in question-and-answer form with an appendix. It also contains the 10-point program of the AMA.

Revision of Constitution and By-Laws of the AMA

Of considerable moment were the activities of a reference committee on changes of the Constitution and By-laws of the AMA. Dr. F. F. Borzell of Pennsylvania was chairman of the committee. A preliminary report was made and final action will be taken on the Committee's proposals at the Atlantic City meeting. Any member who has any ideas relative to changes in the Association's Constitution and By-laws should communicate them to the Secretary's office.

Rich Report

The report on a survey of the AMA's public relations activities, headquarters organization and personnel by a firm of efficiency experts is available to members of the Society for perusal at the Society's office. This report is under copyright. Already a number of the recommendations have been carried out. There is now a Department of Public Relations. Radio programs have been extended. *Hygeia* has been given special consideration. The use of this publication as a means of informing the public in regard to health matters is being actively promoted. Frank G. Dickinson, Ph. D., is the new Director of the Bureau of Medical Economics.

Emergency Medical Service

The National Emergency Medical Service Committee of the AMA, Dr. Edward L. Bortz, Chairman, has been most active in fact-finding. The Committee contemplates making recommendations for better utilization of medical skills and resources in future emergencies. It is most important for the country's welfare that the physician in the armed services or indeed in civilian life in time of emergency serve in a position consistent with his antecedents and training.

Of 1,000 pilot questionnaires sent to physicians by the Committee, 470 were returned. Thus encouraged, the Committee later mailed 50,000 questionnaires to physicians of which 18,000 have been returned, many accompanied by letters. The data provided will prove of the greatest value to the Committee.

In a report to the House, presented by the Chairman, Dr. Walter G. Phiffen, the Reference Committee on Emergency Medical Service, of which your delegate was a member, commended the activities of the Committee on National Medical Service. It was recommended that the Committee's program be broadened to include care of the civilian population in emergencies.

Dr. Herbert P. Ramsey, newly elected delegate, to be seated at the Atlantic City meeting, was present at all meetings, as was Mr. Theodore Wiprud, Secretary.

In closing this report, it might be added that members of the Society would do well to interest themselves in the activities of our representative body, the House of Delegates. Attend as many sessions as possible. Make known your constructive criticisms on legislation.

C. B. Conklin, M.D.
Delegate

SWANSON SUCCEEDS MC INTIRE AS SURGEON GENERAL OF NAVY

Rear Admiral Clifford A. Swanson, M.C., U.S.N., was sworn in as Surgeon General of the Navy and Chief of the Bureau of Medicine and Surgery, December 2, 1946, succeeding Vice Admiral Ross T. McIntire. The ceremony took place in the office of Secretary of the Navy James Forrestal.

Admiral Swanson is widely recognized for his outstanding work in ophthalmology and otolaryngology. Born in Marquette, Michigan, June 6, 1901, he graduated cum laude from the University of Michigan School of Medicine, Ann Arbor, Michigan, in 1925. Later he graduated from the Postgraduate School of the University of Pennsylvania, Philadelphia. He entered the Medical Corps of the U. S. Navy in June, 1925, as Lieutenant (junior grade), and subsequently advanced through the various grades to that of Captain on April 1, 1943. He was promoted to the rank of Rear Admiral at the time of appointment by President Truman.

At the outbreak of World War II, Admiral Swanson was serving on the staff of the Naval Medical School, Naval Medical Center, Washington, D. C. Early in the war period he served as senior medical officer of the battleship *Iowa* and later as medical officer on the Staff of the Commander, Battleships, U. S. Atlantic Fleet. During the latter part of the War, and prior to his new appointment, he was on duty at the Naval Dispensary in Washington as Chief of the Eye, Ear, Nose and Throat Department, and as its chief operating surgeon.

During the War, Admiral Swanson engaged in research on color vision and night vision. He also made studies on the effect of increased barometric pressure on the eye, which were of tremendous value in deep-sea diving. Further, he made tabulations of oxygen consumption under varied barometric pressures which were valuable in the aviation field.

He was appointed by the Surgeon General of the Navy to represent the U. S. Government at the Pan American Eye Congress at Montevideo, Uruguay, and as medical officer accompanying the Congressional Committee on an inspection of the Pacific War Area. For his services on these special assignments and in connection with medical research, he was awarded a Letter of Commendation by the Secretary of the Navy, with authorization to wear the Commendation Ribbon. In addition to the Commendation Ribbon, Admiral Swanson was given the American Defense Service Medal, the American Area Campaign Medal, the European-African-Middle Eastern Area Campaign Medal, and the World War II Victory Medal.

He holds fellowship in the American College of Surgeons, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology. He is also a diplomate of the American Board of Otolaryngology and the American Board of Ophthalmology. He has contributed a number of articles to medical journals.

Vice Admiral Ross T. McIntire was appointed

Surgeon General of the Navy, December 1, 1938, by President Franklin D. Roosevelt. He was the twenty-third Chief of the Bureau of Medicine and Surgery. Born in Salem, Oregon, on August 11, 1889, he obtained his premedical education at Willamette University. In 1912 he graduated from the Medical School of Willamette University, now the University of Oregon School of Medicine.

Rear Admiral Clifford A. Swanson
New Surgeon General of the Navy

At the beginning of World War I he was commissioned an Assistant Surgeon in the Medical Corps of the U. S. Navy with the rank of Lieutenant (junior grade). From July 22, 1917 until January, 1920, he served at sea on board the *U.S.S. New Orleans.* He holds the Victory Medal with Escort Clasp for this service.

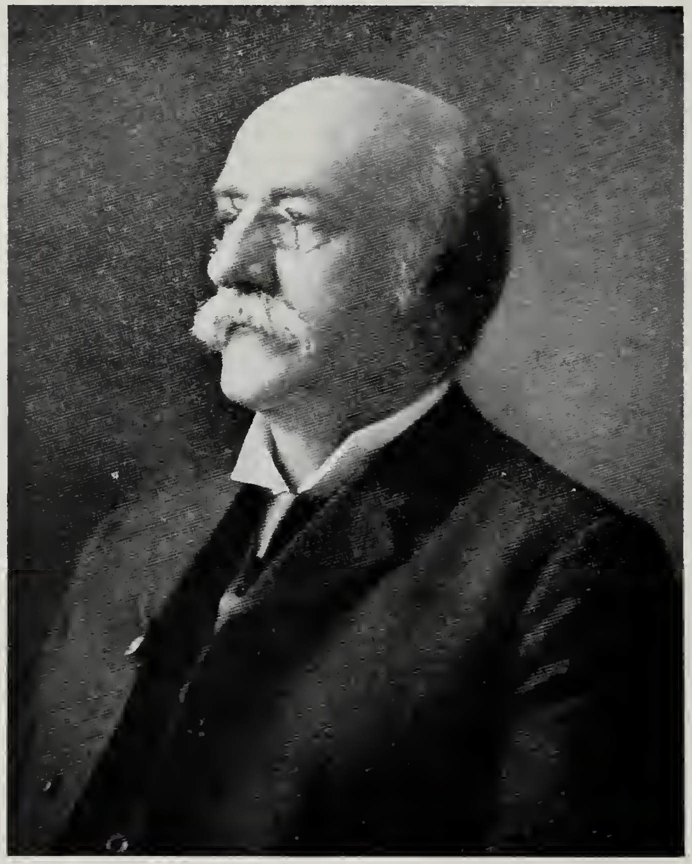
In the summer of 1921 he was appointed head of the eye, ear, nose and throat department of the Naval Hospital, San Diego, Calif. He also served twice at sea on the hospital ship, the *U.S.S. Relief*, both times as head of the OALR department. In 1931 he returned to the Naval Hospital, Washington, and to additional duty as instructor in ophthalmology and otolaryngology at the Naval Medical School. In March, 1933, he was assigned to temporary additional duty as physician to the White House, and on February 13, 1935, he was appointed physician to the White House with additional duty at the Naval Hospital. He accompanied the President on his numerous inspection trips with the fleet at sea or to overseas bases, and also on official journeys ashore.

Dr. McIntire, who is a specialist in ophthalmology and otolaryngology, is a member of many scientific organizations. He is an Honorary Member of the Medical Society of the District of Columbia, a Fellow of the American Medical Association, a Fellow and member of the Board of Governors of both the American College of Physicians and the American College of Surgeons, a member of the National Board of Medical Examiners, as well as a member of the American Surgical Association, the American Psychiatric Association, the American

Rear Admiral Ross T. Mc Intire
Retiring Surgeon General of the Navy

(Continued on page 56)

Washington Physicians of Yesterday



ALBERT FREEMAN AFRICANUS KING, M.D., A.M., LL.D.

Dr. Albert Freeman Africanus King was born January 18, 1841, in Oxfordshire, England, the son of Dr. Edward and Louisa (Freeman) King. His father was active in colonization schemes, and for that reason bestowed the name Africanus. Coming to America in 1851, Dr. King was graduated from Columbian Medical College in 1861, and from the University of Pennsylvania in 1865. He served for three months in 1864 as Acting Assistant Surgeon in the United States Army. He was a very active and influential member of the Medical Society and Medical Association of the District of Columbia, serving as Secretary of the Society, 1865–68, President of the Society in 1883 and of the Association in 1903–04. He was also a member of many other American and British scientific bodies. From 1871 to 1913 he was Professor of Obstetrics in the Medical Department of Columbian (later George Washington) University, and of the University of Vermont; and from 1879 to 1894 was Dean of the Columbian Medical School. He was the author of a Manual of Obstetrics, which went through eleven editions from 1882 to 1910, and was widely used as a textbook and manual on that subject. On October 17, 1894, he married Ellen Amory Dexter; they had one son and two daughters. He died December 13, 1914. A number of biographical and appreciative sketches relating to him were published in the *Washington Medical Annals* for 1915, vol. XIV, pages 89–110.

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THE WARWICK MEMORIAL CLINIC FOR CANCER AND ALLIED DISEASES

CALVIN T. KLOPP, M.D.
Director, Warwick Memorial Clinic

The Warwick Memorial Clinic was formally opened on June 1, 1933. The Clinic is an endowed institution of the Washington Home for Foundlings. It is located within the grounds of Garfield Memorial Hospital, on a site purchased from that institution. It owns and operates its own building with the aid of certain contracts with: (1) Garfield Memorial Hospital, (2) Drs. Groover, Christie and Merritt, and (3) Drs. Lindsay, Rice, Selinger and Cassidy. The Clinic accepts for diagnosis and treatment any case of cancer and allied diseases.

HISTORY OF THE CLINIC

In his will, the late Randolph T. Warwick made a bequest unto the Washington Hospital for Foundlings for the erection and maintenance of a memorial building, to be known as "The Helen L. and Mary E. Warwick Memorial," to be used for the care and treatment of foundlings and for the care and treatment of women afflicted with cancer. In 1924 the powers of the Washington Hospital for Foundlings were enlarged by an Act of Congress in order to allow this association to receive, accept and hold the bequest and devise contained in the will of the late Randolph T. Warwick.

In 1932 an agreement was made between Garfield Memorial Hospital and the Washington Home for Foundlings. As the latter intended to erect and maintain a building known as "The Helen L. and Mary E. Warwick Memorial" to be used for treatment of cancer, and as it was realized that coöperation between Garfield Hospital and the Foundlings Home would make for better efficiency and greater economy in construction and operation of the Warwick Memorial building, both parties agreed to its erection on the present site, within the Garfield grounds, joined to the hospital by a ramp, and interrelated by administrative agreements, all so arranged that neither institution should profit at the expense of the other.

In 1933 another agreement was made between Garfield Hospital and the Washington Home for Foundlings in order to more fully equip the Clinic with all necessary X-ray apparatus. This agreement provided for joint ownership of the majority of the equipment by both institutions. At the same time an agreement was made between (1) Garfield Memorial Hospital and the Washington Home for Foundlings, and (2) Drs. Groover, Christie and Merritt, for the operation of the department of radiology by the latter. In the same year still another agreement was made between the Washington Home for Foundlings and Drs. Lindsay, Rice and Selinger, providing that the latter operate the pathology laboratory in the Warwick Clinic. These agreements, with certain modifications, remain in effect up to the present time.

Under these agreements, the Warwick Memorial Clinic began operation on June 1, 1933. The department of radiology (under Dr. Merritt) and the pathology department (under Dr. Lindsay) grew rapidly in conjunction with the corresponding departments of Garfield Hospital, as an integral part of which they were conducted. While the "clinic" aspect of the Warwick was not strikingly evident in the early years, the groundwork for the accomplishment of its real purpose, namely, the treatment of cancer, was laid. The organization and maintenance of a full diagnostic and therapeutic clinic, including both radiation and surgical therapy, were begun. A large amount of material was collected in its files for later evaluation.

As medical personnel in civilian institutions became depleted by the needs of military service, it was inevitable that the "clinic" features remain more or less in abeyance. During these years Dr. E. A. Merritt and Dr. J. W. Lindsay and their staffs took full responsibility for the Clinic and cared for all patients, although they were handicapped by lack of personnel. They arranged suitable consultations with members of the Medical Staff, but no regularly scheduled cancer clinics were held.

As the war years drew to a close, the Board of Directors of the Washington Home for Foundlings, on the advice of Dr. William Charles White, arranged for Dr. John Wirth of the U. S. Public Health Service, and Chief of the Tumor Clinic of the Marine Hospital in Baltimore, to study the Warwick Clinic.

After a brief survey, Dr. Wirth urged that steps be taken as soon as possible to advance coöperation between the various units of the Clinic in order to assure a coördinated clinical service, with proper provision for consultation between surgeon, radiologist, pathologist, and internist. In this way, the separate units would assume their proper places in a broad general organization. This would provide (1) a group of physicians primarily interested in the cancer problem, to whom patients suffering from cancer might be referred, and (2) would result in the establishment of a true cancer clinic and the intimate integration of a previously loosely knit group of services.

In order to carry out these recommendations, the Executive Staff of Warwick Clinic requested that the Board of the Washington Home for Foundlings appoint a director of the Warwick Memorial Clinic. It was to be the duty of the director to work with the Executive Staff of Warwick in establishing a true cancer clinic which would meet the requirements of the American College of Surgeons, and would offer the best possible facilities for the diagnosis and treatment of patients with cancer and allied diseases. Dr. Calvin T. Klopp was appointed Director by the Board of Washington Home for Foundlings, with the approval of the Executive Staff of Warwick Memorial Clinic. Under his direction the Clinic began reorganization in June 1946. The plans of the reorganization fulfill the purpose of the endowment as originally outlined in 1933.

PURPOSES OF THE CLINIC

These are as follows:

1. To attempt to insure the best possible care for any cancer patient through:
   (a) Group consultation between those departments versed in various methods of diagnosis and treatment.
   (b) Establishment of a permanent organization to furnish an educational source for any physician interested in cancer.
   (c) Maintenance of complete follow-up records on all its cancer patients in order to evaluate treatment, and to insure early additional treatment as required.
   (d) Maintenance of an active social service department to insure adequate social and economic help to the patient and his family.
2. To provide facilities for cancer prevention and cancer detection examinations.
3. To provide training for young physicians in the field of oncology.

ORGANIZATION OF THE CLINIC

I. Administration:

The Clinic is controlled by the Board of the Washington Home for Foundlings. The Board consists of the following members:

Mr. Walter S. Pratt, Jr., President
Mr. Victor B. Deyber, First Vice President
Mrs. B. Taylor, Second Vice President
Mr. Remick S. Ferguson, Secretary
Dr. William S. Anderson
Mr. Fountaine C. Bradley
Mrs. Daniel Devore
Colonel Joseph Fairbanks
Mr. Alfred Lawson
Mrs. Joseph C. Longridge
Mrs. A. C. Oliphant
Mrs. Douglas R. Phillips
Miss Anne W. Rogers
Mrs. W. H. Sholes
Mrs. Donald D. Shepherd
Mr. Clarke Slade
Mrs. Wendell P. Stafford
Mrs. Camp Stanley
Dr. Wm. Charles White
Mrs. Lloyd B. Wilson

This Board has employed the following personnel, on recommendation of the Executive Staff of Warwick Memorial Clinic:

1. Medical Director—Calvin T. Klopp, M.D.
2. Graduate Social Service Worker—Catherine Greenville
3. Clinic Secretary—Claire E. Kennedy
4. Clinic Nurse—Doris E. Craver
5. Fellow in Oncology (to be appointed)—a trainee of the National Cancer Institute

II. Staff

A. *Executive*

The Clinic has a permanent Executive Staff appointed by the Board of Washington Home for Foundlings. They are:

1. Chief of Surgery—Dr. H. H. Kerr
2. Chief of Pathology—Dr. J. W. Lindsay

3. Chief of Internal Medicine—Dr. L. C. Ecker
4. Chief of Radiology—Dr. R. M. Caulk
5. Director of the Clinic—Dr. C. T. Klopp

B. *Associate*

The Associate Staff consists of those physicians who are interested in the cancer problem and who will devote sufficient time to the care of a given group of cancer patients in the Clinic. They are appointed by the Board of Washington Home for Foundlings, on nomination of the Executive Staff of Warwick Clinic, for a term of twelve months. They are designated by name to a given division of the Clinic. They are aided by advice from the Executive Staff, or suitable senior consultants designated by the Executive Staff. At present the Staff consists of:

Dr. Henry Ecker—Internal Medicine
Dr. J. Keith Cromer—Gynecology
Dr. Thomas Bradley—General Surgery
Dr. W. D. Jarman—Urology
Dr. Edgar Davis, Dr. Roy Klepser—Thoracic Surgery
Dr. Roy Hertz—Endocrinology

III. Departments:

A. *Admission Department*

All new patients are seen here. A history and physical examination are done. Necessary laboratory and diagnostic studies are completed. A working diagnosis is established. Only patients proven to have or suspected of having a malignant tumor are referred beyond this department. Any others are discharged from the Clinic. This department is supervised by the Director.

B. *Consultation Department*

All suitable patients are referred from the Admission to the Consultation Department which consists of the Tumor Board. This Board is composed of:

1. The Chief of Surgery
2. The Chief of Pathology
3. The Chief of Radiology
4. The Chief of Internal Medicine
5. The Director of the Clinic
6. The member or members of the Associate Staff whose cases are being reviewed. (Alternates may be appointed from the Associate Staff.)

This Board meets as often as is necessary. At present, it meets each Tuesday, at 3:00 p.m., in the Kellogg Building of Garfield Memorial Hospital. Any physician may attend these meetings. The Board reviews the diagnosis in each problem case and makes recommendations as to treatment. These recommendations are forwarded to the referring physician if the patient has been referred for this purpose only. If the patient also is referred for treatment, these recommendations are carried out by the Staff of Warwick Clinic.

C. *Treatment Department*

This consists of the entire Staff of the Clinic. The actual member or members responsible for treatment of a given case are designated by the Tumor Board at time of previous consultation. It is planned to divide cases into anatomic groupings for purposes of assignment. These groupings are as follows:

Clinic	*Scheduled Day for Clinic*
1. Head and Neck	Friday P. M.
2. Breast	Friday P. M.
3. Skin, Soft Tissue and Bone	No definite schedule
4. Gastric	Wednesday P. M.
5. Rectal and Colon	Wednesday P. M.
6. Genitourinary	No definite schedule
7. Gynecologic	Wednesday A. M.
8. Thoracic	Monday P. M.
9. Lymphoma	No definite schedule

Roentgen therapy is carried out in Warwick Clinic. Minor surgery and minor radium treatments are done in Warwick Clinic. Major surgery is done (by agreement) in Garfield Hospital. Patients requiring hospitalization are cared for in Garfield Hospital by the Warwick Staff.

D. *Follow-up Department*

After treatment has been completed, all patients are followed at determined intervals by the Staff of the Clinic. Cases are to be grouped according to the previously outlined anatomic divisions. These examinations secure a careful evaluation of the efficacy of any form of treatment, and the early detection and treatment of recurrent, residual or metastatic disease. These follow-up examinations are an essential and necessary part of complete cancer treatment. They serve to treat the cancer and *not* the patient in general, and are not to interfere with his relation to his family physician.

E. *Social Service Department*

Cases are referred to Social Service by the following sources:

1. The Staff Physician
2. The Admitting Secretary

All cancer cases are known to this department, but service is offered only when the need is indicated. All cases are referred to Social Service when a medico-social problem is involved.

Casework services are offered to the patient and his family regarding:

1. Hospitalization when a financial problem is involved.
2. Plans for financial aid for either the patient or his family when, due to the patient's disability, the financial status of the family is such that they can no longer meet their present needs. This financial assistance is met by referrals to other social agencies who offer this type of service.
3. Assistance to both the patient and his family in the acceptance of the patient's disability and the problems involved.
4. Plans for convalescent care when requested by the doctor.
5. Plans for nursing home care of terminal cases when requested by the doctor.

The other functions of the Social Service Department are:

1. To determine the charge, if any, to be paid by the patients of the lower income group for examination and treatment in the Clinic.
2. To follow-up all cancer cases at the request of the Staff physician. Follow-up is done through the family physician whenever possible.

RELATION OF THE DIRECTOR TO WARWICK CLINIC

The Director of the Clinic is responsible to the Board of the Washington Home for Foundlings for the organization, maintenance and operation of a proper cancer clinic. He has an office at the Clinic for this purpose and actively participates in the diagnosis and treatment of designated clinic cases. By agreement with the Board of the Washington Home for Foundlings and the Executive Staff of Warwick Clinic, he also maintains an office at the Warwick Clinic for the private practice of general surgery, limited to diagnosis and treatment of cancer and allied diseases.

RELATION OF THE WARWICK CLINIC TO GARFIELD HOSPITAL

On November 20, 1946, the Executive Medical Staff of Garfield Memorial Hospital passed the following resolution:

> "That the Executive Medical Staff recommend to the Board of Directors of Garfield Memorial Hospital that it accept the Warwick Clinic as an associated institution to function as a Tumor Board; and that the Staff services of Garfield Memorial Hospital, in all cases of suspected malignancy, shall consult with the Tumor Board and offer all appropriate cases for diagnosis and treatment at the discretion of the attending physician for a period of one year, and refer all cases of malignancy for follow-up."

This will allow Warwick Clinic to include the Tumor Clinic of Garfield Memorial Hospital as one of its component parts.

RELATION OF WARWICK CLINIC TO THE GARFIELD LADIES' AID CANCER PREVENTION CLINIC

There has been established this month (December 1946) the first Cancer Prevention Clinic in Washington. Sponsorship is by the Ladies' Aid of Garfield Memorial Hospital. Space and medical supervision are provided by the Warwick Memorial Clinic. Patterned after the clinics of the Donner Foundation in Philadelphia and the Kate Depew Strang Memorial in New York, this clinic provides periodic examination at low cost. Findings are reported to the patient's own physician. No recommendation regarding treatment is given. The purpose is to show either the absence of cancer or to detect the earliest stages.

The number of patients accommodated will depend upon the amount of financial aid and personnel available. Contributions are accepted from patients to help defray costs. In the beginning there will be one or two clinics a week. This number will be increased as need develops and as help is available. The Garfield Ladies' Aid seeks to provide a place where people of Washington may present themselves at periodic intervals and at low cost, to be examined as to the absence or presence of cancer.

The first clinic will be held on Friday a.m., December 27, 1946, and weekly thereafter. Appointments can be made by calling Adams 7500, Ext. 188, any weekday between 9:30 a.m. and 4:00 p.m.

Relation of Warwick Clinic to Drs. Lindsay, Rice, Selinger and Cassidy

Agreements have been made between the Garfield Memorial Hospital and the Washington Home for Foundlings whereby space for pathologic laboratories is provided for the Clinic, together with certain personnel and supplies. Likewise, it is mutually agreed that this space, the supplies, and personnel shall be used for carrying on the pathologic work of the two institutions. By further agreement, it has been arranged that the professional group, i.e., Drs. Lindsay, Rice, Selinger and Cassidy, shall direct the pathologic services of the two institutions, with the provision that they may also conduct such features of the Episcopal and Children's Hospital services as they may desire, and may use the laboratories for their private patients in appropriate cases. Drs. Lindsay, Rice, Selinger and Cassidy are regularly appointed members of the Medical Staffs of the Garfield, Children's and Episcopal hospitals, and the Warwick Memorial Clinic. This group participates in this work by payment of a stipulated sum to the Warwick Clinic, and then makes its own charges and collects its own fees for services rendered on behalf of the Clinic patients.

Relation of Warwick Clinic to Drs. Groover, Christie and Merritt

A member of the organization of Drs. Groover, Christie and Merritt is in charge of the department of radiology. Facilities for both diagnosis and treatment are available. Under an agreement between the above mentioned doctors and the Garfield Hospital and Washington Home for Foundlings, a stipulated sum is paid by this professional group for their use of the space and equipment. This department serves both institutions, and in addition accepts private outpatients for both diagnosis and therapy when referred by a physician.

Fees for professional services to patients who can afford private care are rendered on that basis. Those patients in clinic status are either assessed no charge (if indigent) or a small fee calculated to aid in defraying the cost of material and maintenance of the department.

Source of Patients

Any patient having, or suspected of having, a malignant tumor is eligible for treatment at Warwick Memorial Clinic. All patients are screened by the Clinic secretary and social worker. All patients unable to afford private care are cared for by the Staff and pay only the operating costs of the Clinic, when able to do so. All patients able to afford private care are referred to members of the Staff for care. A positive effort is made (1) to determine if a patient has a family physician, and to contact that physician, and (2) to forward reports to the referring physician in all cases.

Business Administration

A schedule of charges is arranged for clinic care. These charges help to pay the operating expenses of the Clinic. No patient is refused care because of inability to pay. As the Clinic is a non-profit institution, these charges are flexible and are varied to meet the budget of the Clinic. The present schedule of charges is as follows:

1. Initial visit, to include necessary history, physical examination and registration in Clinic, $0.00 to $3.50.
2. All subsequent visits, $0.00 to $1.50.

Laboratory work and diagnostic roentgenographic studies are not included in these charges, nor is the cost of radiation therapy or minor surgery. Patients of all pay grades will pay the clinic rates until a working diagnosis has been established. All patients having a family physician, but not referred to the Clinic by that physician for *both* diagnosis and treatment, will be returned to that physician with the Clinic's recommendation as to diagnosis and treatment. If the family physician wishes to do so, he may request that the Clinic arrange treatment. Patients who can afford the services of a private physician will then be referred to a member of the Staff for private care. Other patients will be cared for as Clinic cases, under the supervision of the Clinic Staff.

Patients having no family physician will be referred to members of the Staff as private cases after a diagnosis has been established, if they can afford private care; or will be cared for under supervision of the Clinic Staff if they cannot afford private care.

News and Personals

The 20th Annual Meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, on February 9. The program will include discussions in the fields of national affairs, economics and medical education. All physicians are invited to attend and may register without fee. Further information may be secured from the Secretary, Dr. Creighton Barker, 258 Church Street, New Haven, Conn.

The U. S. Naval Medical School, National Naval Medical Center, Bethesda, Md., has been sponsoring a series of lectures during the fall months as a supplement to the regular curriculum. These lectures are held on Thursday evenings at 8:15 p.m.

The second series of lectures will begin in February. The following schedule has been announced by Rear Admiral T. C. Anderson, M.C., U. S. N., Medical Officer in Command of the Medical Center.

February 27—Major General Paul R. Hawley, M.C., A.U.S., Veterans Administration: "Knowledge Gained with Respect to the Care of Casualties during the Late War"

March 27—Dr. Tom D. Spies, Cincinnati, Ohio: "Folic Acid in the Treatment of Pernicious Anemia"

April 24—Dr. Frank Lahey, Boston, Mass.: "The Late War's Influence upon Trends in Surgery"

May 29—Dr. R. R. Spencer, National Institute of Health: "What Is New in the Field of Oncology"

June 19—Dr. Abram E. Bennett, Omaha, Nebr.: "Mismanagement of Psychiatric Cases"

Members of the Medical Society are invited to attend and to participate in the social hour and refreshments which follow the scientific session.

CALENDAR OF MEETINGS

December 2	Board of Censors
December 3	Board of Censors Executive Board, Woman's Auxiliary
December 5	Section on Neurology and Psychiatry
December 9	Washington Orthopedic Club
December 11	Scientific Meeting of Society Woman's Auxiliary
December 13	Subcommittee on Maternal Welfare
December 17	Subcommittee on Sanitation District Dental Society
December 20	Compensation Insurance Committee
December 30	Executive Board

The American Board of Obstetrics and Gynecology, Inc., announces that the next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 7, 1947.

Arrangements will be made so far as is possible for candidates to take the Part I examination (written paper and submission of case records) at places convenient for them. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held June 1–7, 1947, at Pittsburgh, Penna. Notice of the exact time and place of the Part I and Part II examinations will be sent all candidates well in advance of the examination date.

For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, Penna.

The Seventh Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1947. The Society will offer a cash prize of $100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine.

Contestants must be members of the American Medical Association and residents of the United States. The winner will be invited to present his contribution before the Twelfth Annual Meeting of the Mississippi Valley Medical Society to be held at Burlington, Iowa, October 1–3, 1947, the Society reserving the exclusive right to first publish the essay in its official publication, the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall be typewritten in English in manuscript form, submitted in 5 copies, not to exceed 5,000 words, and must be received not later than May 1, 1947. Full details may be secured by writing to Dr. Harold Swanberg, Secretary of the Society, 209–224 W.C.U. Building, Quincy, Illinois.

The Committee on Public Health Relations of The New York Academy of Medicine is preparing a new edition of the "Directory of Convalescent Homes in the United States," to be published by the Sturgis Fund of the Winifred Masterson Burke Relief Foundation of White Plains, New York. The last issue of this Directory was published by the Sturgis Fund in 1931, under the auspices of the Committee on Convalescent Care of the American Conference on Hospital Service, and has long been out of print. The need of a new directory is recognized by all concerned.

Early in January, a questionnaire will be distributed to all recognized convalescent homes maintained by municipalities, counties or voluntary bodies. The information sought deals with the physical plant, the staff, the requirements for admission, the type of patients, therapy, and such other matters as will make the Directory a dependable guide for physicians who wish to refer their patients to institutions for convalescence. The questionnaire is so devised that it can be filled out with a minimum of effort. Convalescent homes that do not receive a questionnaire are urged to request one by writing to E. H. L. Corwin, Executive Secretary, Committee on Public Health Relations, The New York Academy of Medicine, 2 East 103rd Street, New York 29, New York.

Among those who attended the recent **Supplemental Session of the House of Delegates of the American Medical Association** in Chicago, December 9 to 11, were Dr. C. B. Conklin, the Society's official delegate; Theodore Wiprud, Secretary of the Medical Society; Dr. Joseph E. Lawrence, Director of the Washington Office of the Council on Medical Service and Public Relations of the AMA; and Dr. Herbert P. Ramsey, who will be seated as the Society's second delegate when the AMA convenes in June.

Dr. Wallace M. Yater, Dr. Ramsey, and Mr. Wiprud were present at the **Conference of State Secretaries and Editors,** December 7 and 8, just preceding the meeting of the House of Delegates of the AMA. Mr. Wiprud read a paper on "The Medical Editor Consults His Readers" before the session for Editors, December 7.

Mr. Wiprud was elected Chairman of the Program Committee for the 1947 Conference of State Secretaries and Editors, which will be held in Chicago next December. Other members of the Committee are Dr. Douglas L. Cannon, Secretary of the Alabama Medical Association; Dr. Dwight L. Wilbur, Editor of *California Medicine*; Mr. Jonathan Forman, Editor of the *Ohio State Medical Journal;* and Mr. Harvey T. Sethman, Executive Secretary of the Colorado State Medical Society.

Dr. Yater went on to Rochester, Minn., following the Conference, where he gave an address on "Coronary Artery Disease in Young Men" at the Mayo Clinic.

Theodore Wiprud was elected Chairman of the **Conference of Medical Society Executives** at an organization meeting which was held at the Hotel Drake in Chicago, December 10. Fifty-two members or prospective members of the Conference attended, representing state and county societies in 24 states, the American Medical Association, and the American College of Radiology. The purpose of the organization is "to enable medical society executives to improve the quality and efficiency of their services to their respective societies and to the medical profession generally; to provide a mechanism for the exchange of information and experience among medical society executives for mutual improvement, and for fellowship."

Other officers elected were Mr. Charles S. Nelson, of Ohio, Vice Chairman; Mr. James E. Bryan, of New York, Secretary-Treasurer; Mr. John Hunton, of California, and Miss Agnes V. Edwards, of Virginia, members of the Executive Committee.

The Silver Spring Academy of Medicine has invited Dr. Winfred Overholser to be guest speaker, February 3. His address on "Recent Developments in Psychiatric Diagnosis and Treatment" will be discussed by Dr. Norman Q. Brill. The series of meetings sponsored by the Academy are being held in the New Montgomery County Building, Colesville Road, near the corner of Georgia Avenue, in Silver Spring, Md., beginning at 8:00 p.m. All members of the Society are invited to attend.

The George Washington University School of Medicine will open its **Second Annual Series of Intensive Postgraduate Courses** on January 27, to continue through March 14. The list of courses appeared on page ix of the December ANNALS. The fee for each course is $50 per week. For eligible veterans all fees are covered by the allowance of the G.I. Bill of Rights. The W. K. Kellogg Foundation, of Battle Creek, Michigan, has provided another grant this year in support of this postgraduate program.

The American Psychiatric Association has designated a number of leaders in the field of psychiatry to organize The Psychiatric Foundation, which will mobilize both lay and medical leaders in the fight against mental ills in America. The new Foundation will be sponsored by the American Neurological Society. Dr. Leo H. Bartemeier of Detroit, Secretary-Treasurer of the American Psychiatric Association, will be Chairman of the Organizing Committee. Dr. Winfred Overholser will serve on the Committee.

A Committee consisting of **Dr. Arthur C. Christie and Dr. Harold W. Jones of the Association of Honorary Consultants to the Army Medical Library** are taking steps for the eventual incorporation of the Association. This move is being made as the result of a unanimous vote of the members at the recent annual meeting. It is felt that it will facilitate the handling of moneys which the Association has at its disposal, and it is also hoped that additional gifts and legacies will thus be encouraged.

Dr. Harry H. Kerr, Chief Surgeon of Garfield Hospital, has been elected President of the newly incorporated **District Division of the American Cancer Society.** The new Division announces that the cancer control program will be preceded by a survey of cancer needs in the District, paid for by U. S. Public Health Service funds granted the District Health Department. The survey director will be chosen by Health Officer Ruhland from a list of cancer experts compiled by Dr. Calvin T. Klopp, Director of the Warwick Memorial Cancer Clinic in Garfield Hospital.

Other officers of the District Division of the American Cancer Society are Eliot Wadsworth, former Assistant Secretary of the Treasury, Vice President; Dr. Klopp, Secretary; Frederick P. H. Siddons, Vice President of the American Security and Trust Company, Treasurer; and George E. Hamilton, Jr., attorney, Counsel.

The new group is similar to the state divisions of the national organization and will start a program to teach the public how to recognize early signs of cancer and to encourage and develop clinics for the diagnosis and treatment of cancer.

The incorporators held their organization meeting at the Metropolitan Club, November 18. In addition to the officers, those present were Dr. William P. Herbst, President of the Medical Society; Dr. Roger M. Choisser, Professor of Pathology at George Washington University; Dr. William Charles White of the National Research Council; and Samuel H. Kauffmann, Business Manager of the *Washington Star.*

A nonprofit organization for the study of the treatment of diabetes in the Washington area has been incorporated under the name of **Washington Diabetes Association, Inc.** Drs. Maurice Protas, Clarence E. Rice and John A. Reed are listed as trustees. Dr. Reed will act as resident agent of the Association. The Association has been formed for educational purposes and scientific research in diabetes, and to develop standards of treatment of the diabetic patient, institutional or otherwise, in the District of Columbia Metropolitan Area.

At the meeting of the **Executive Board,** October 28, President William P. Herbst submitted the names of **Dr. Robert H. Groh** as Chairman and **Dr. Robert J. Coffey,** Vice Chairman, of the Committee on Arrangements for the 18th ANNUAL SCIENTIFIC ASSEMBLY of the Society. The appointments were approved by the Board.

Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, was selected by the Board to be the **Kober Memorial Lecturer for 1947.**

On November 25, the Board appointed **Dr. Robert J. Coffey** as delegate to the Interprofessional Conference, succeeding Dr. John A. Reed, who recently resigned. The attention of the Board was directed to the provisions of the By-laws of the Conference that the three delegates representing the Medical Society be appointed for one, two and three years, respectively. The Board voted that the Society's representatives should serve as follows: Dr. Thomas F. Collins, three years; Dr. Emmett G. Coiner, two years; Dr. Robert J. Coffey, one year.

Dr. Morton S. Kaufman was appointed to the Subcommittee on Maternal Welfare.

In response to many requests from practicing physicians, medical schools, and health departments, **the Venereal Disease Division of the Public Health Service** is assembling in one central collection a large number of clinical photographs in natural color of the lesions and other visible evidences of the venereal diseases. These photographs will be mounted for use as projection slides or for reproduction in publications. Each will be identified with the diagnosis, the source of the photograph, and with other pertinent information The entire collection will be catalogued and made available on a loan basis to medical schools and libraries, health departments, medical societies, authors of textbooks and monographs, and other professional individuals or agencies interested in venereal disease diagnosis, treatment, control and research.

The physicians who participated in the **Sixth Annual Physicians' Golf Tournament** voted that the moneys in excess of expenses be turned over to the Children's Hospital for its building fund. This amounted to $125.00 and a check for that sum was sent to the Hospital.

NOTICE TO MEMBERS

The books of Group Hospitalization, Inc., will be open again to new subscribers for the Doctors Group, March 1. Applications must be in the hands of the Society's Secretary by February 20 or earlier. Please telephone District 3111 for application blanks and any information.

The Washington Ophthalmological Society will hold a special meeting in conjunction with the George Washington University Postgraduate Course on Monday evening, February 3, at 8:00 p.m. in the Medical Society's building. The following program will be presented: "Selected Cases of Retinal Detachment," Dr. Peter C. Kronfeld, Chicago, Ill.; "The Problem of Thyrotropic Exophthalmos," Dr. F. Bruce Fralick, Ann Arbor, Mich.

The Clinico-Pathological Society met December 17 at the home of Dr. William H. Jenkins. One paper was presented, "Cancer of the Cervix," by Dr. Henry L. Darner.

The third meeting of the **George Washington University Medical Society,** December 21, was devoted to a discussion of the George Washington University Medical Center with special reference to the organization of the staff and the equipping of the new University Hospital. Speakers were Dr. Cloyd Heck Marvin, President of the University; Major General U. S. Grant III, Chairman of the Equipment Fund Committee; Robert V. Fleming, Chairman of the Board of Trustees; Dr. Walter A. Bloedorn, Dean of the School of Medicine; and Dr. Charles Stanley White, member of the Board of Trustees and Chairman of the Medical Alumni Committee of the Hospital Equipment Fund.

Dr. Oscar B. Hunter, Secretary of Doctors Hospital and the Columbia Medical Building Corporation, has announced that a three-story addition to the present north wing of Doctors Hospital will be constructed as soon as Government approval and materials can be obtained. This will bring the north wing up to the 10-story height of the rest of the institution. The three additional stories will provide

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space for expanded laboratory facilities, classrooms and more beds. Estimated cost is $125,000.

In addition to the building now under construction on 19th Street near I Street, there is planned a new building to house facilities for additional X-ray equipment for the firm of Groover, Christie and Merritt. The X-ray building will include one story and basement and is planned for construction soon at a cost of about $20,000. It will be built next to the Columbia Medical Building addition.

The Maryland-District of Columbia Hospital Association chose James G. Caposella, Superintendent of Emergency Hospital, President-elect at its sixth annual meeting at Hotel Statler, November 25 and 26. The new President of the Association is Dr. Edwin L. Crosby, Director of Johns Hopkins Hospital, Baltimore, who succeeds Dr. Merrell L. Stout, of Baltimore.

Mr. L. G. Schmelzer, Superintendent of George Washington University Hospital, and Mr. Karl York, Administrator of the Arlington Hospital, were selected as Delegate and Alternate, respectively, to the House of Delegates of the American Hospital Association.

The District of Columbia Pharmaceutical Association has announced plans to solicit member stores in an effort to equip the pharmacy department of the new George Washington University Hospital. Cochairmen for the drive will be Irving Tennyson and Samuel Bialek.

Of interest to service physicians of World War II is the announcement by the **Veterans Administration** that veterans who have National Service Life Insurance now may be insured against total disability. Total disability income benefits authorized by recent legislation may be added to any plan of NSLI upon application, proof of good health, and payment of an extra premium. Premium rates for the disability coverage range from 6 cents to 94 cents a month per $1,000 of insurance, depending on the insured's age and type of policy.

The disability benefits are at the rate of $5 a month for each $1,000 of insurance and are payable after the veteran has been totally disabled continuously for 6 months or more. The monthly benefits will continue to be paid as long as the insured remains totally disabled. However, the disability must commence before the veteran's 60th birthday.

One of the features of the new disability benefit, VA officials said, is that the face value of the veteran's policy will not be reduced by any disability payments that he might receive. VA said that veterans with service-connected disabilities less than total in degree are not prevented from taking advantage of the new provision, provided they apply for it before January 1, 1950. In these cases, such disabilities are waived if they are the only bar to meeting the health requirements.

Veterans who wish to obtain full information regarding the new disability income feature should contact their nearest VA office.

Dr. Montgomery Blair will become Director of **Children's Hospital,** February 15, succeeding **Miss Mattie M. Gibson,** who has served as Superintendent of the Hospital for the last 26 years and who will retire to become Superintendent Emeritus. Mr. John J. Anderson, who has served under Miss Gibson as Assistant Superintendent, will become Assistant Director.

Miss Gibson, dean of Washington hospital superintendents, came to the Hospital in 1920 with a notable nursing record. She trained at Women's Christian Association (now Jennie Edmundson) Hospital in Council Bluffs, Iowa, and was one of the first nurses to volunteer for overseas service with the Army in World War I. Miss Gibson and eight companions in Mobile Hospital No. 1 moved to every American front during that war. For her work she received the Croix de Guerre with Bronze Star. Following the Armistice she nursed for a time at Council Bluffs, then resigned to help the Navy fight the influenza epidemic at Great Lakes Training School.

Dr. Blair graduated from Harvard Medical School in 1925 and served his internship at St. Luke's Hospital in New York from 1925 to 1927. He was resident physician in bacteriology at Children's Hospital in Boston, 1927–28, and an intern at the same hospital, 1928–30. From 1930 until 1942, when he was commissioned a Major in the Army Medical Corps, he practiced pediatrics in the District. In 1943 he was promoted to Lieutenant Colonel. Dr. Blair served as Assistant Chief of the Medical Service, Torney General Hospital, Palm Springs, Calif., for

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one and one-half years and as Chief of Medical Service, Birmingham General Hospital, Van Nuys, Calif., for about a year before he went overseas in the fall of 1944. He served as Chief of Medical Service with the 220th and 297th General Hospitals in the European Theater.

Dr. Blair is Associate Visiting Physician at Children's and Garfield Hospitals and consultant in pediatrics at Emergency Hospital. He was formerly Medical Director of the Children's Country Home.

Star Staff Photo

Dr. Montgomery Blair, new Director of Children's Hospital, Miss Mattie M. Gibson, retiring Superintendent, and Mr. Charles D. Drayton, President of the Board of Directors.

Several members of the Medical Society participated in the recent **Conference of Examining Physicians of The Chesapeake and Potomac Telephone Companies,** which was held at the Shoreham Hotel, December 5 and 6. Present at the Conference were representatives from Maryland, Virginia, West Virginia and the District of Columbia. Among those who attended from Washington were Dr. R. Lomax Wells, Medical Director of the C. and P. Telephone Companies, Drs. L. M. Cuvillier, M. J. Foret, F. Y. Jaggers, H. F. Kreuzburg, B. E. Nunez, J. A. Norcross, W. G. Puryear, J. A. Reisinger and J. U. Schwarzmann. Dr. Edward J. Stieglitz presented a paper on "The Cardiac in Industry" during the Conference and Dr. George Ruhland spoke on "The Community Health Officer and the Industrial Physician."

At the annual business meeting of the Attending Staff of **Suburban Hospital,** November 19, 1946, Dr. Edward J. Stieglitz was reëlected Chairman of the Executive Committee of the Medical Staff. Also reëlected were Dr. Arch L. Riddick as Vice Chairman and Dr. William F. Burdick as Secretary. Drs. Walter W. Boyd, Charles R. L. Halley, Frederick C. Fishback, Sidney C. Cousins, G. Haven Mankin and Barton W. Richwine, in addition to the above officers, were elected to the Executive Committee for the year 1947.

Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, will take office as the first woman President of the **American Public Health Association** when it holds its 75th annual meeting in Atlantic City next fall. This announcement was made at the recent annual meeting of the Association in Cleveland, November 12–14.

Dr. Eliot is well known to all physicians. She is a Fellow of the American Medical Association, the American Academy of Pediatrics, and the American Public Health Association. Last summer she was Vice Chairman of the United States delegation at the World Health Conference in New York.

Dr. Eloise W. Kailin was a guest speaker at the annual meeting of the American Academy of Allergy, November 25 to 27, 1946. She presented two papers: "Factors Influencing Reagin Formation in Active Experimental Human Sensitization to Ascaris Lumbricoides Antigen. II. The Influence of Sex as a Factor in Rate of Sensitization" and "III. The

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Influence of Race as a Factor in Rate of Sensitization, with Further Observations as to the Influence of Sex." Both papers were prepared jointly with Drs. A. Davidson and M. Walzer.

At this meeting Dr. Kailin was elected to membership in the Academy.

The Compensation Insurance Committee met December 20 at the Society's building to discuss and adjudicate problems arising between physicians and insurance companies. Members of the Committee are Dr. W. Cabell Moore, *Chairman*, Dr. Frank E. Gantz, and Dr. Donald W. Mitchell. The Compensation Committee of the Claim Men's Association is composed of Mr. Charles B. DeShazo, *Chairman*, Mr. Frank W. Glenn, and Mr. H. C. Myers.

Society members doing workmen's compensation work who become involved in disagreements with insurance carriers should communicate with Dr. W. Cabell Moore, Chairman, Compensation Insurance Committee, 1718 M Street, N.W., Washington 6, D. C.

Copies of the Workmen's Compensation Fee Schedule can be obtained at the Society's office.

Dr. Jefferson D. Kernodle has been appointed pathologist at **Alexandria Hospital,** effective January 1, to succeed **Dr. Thomas M. Peery,** who resigned to become director of laboratories at the new George Washington University Hospital. Dr. Kernodle, of Wichita Falls, Texas, is a graduate of the University of Arkansas School of Medicine, and has studied at the Medical College of Virginia, Richmond.

Drs. Clayton H. Hixson, Lloyd H. Mousel, Andrew G. Prandoni, Monroe J. Romansky, and John A. Washington have recently appeared on the programs of the Professional Staff Proceedings of **Walter Reed General Hospital.** Other members of the Society who are taking part in these programs have been announced previously in the ANNALS.

Dr. William P. Herbst gave an address before the New York Branch of the American Urological Society, November 20, on "The Role of the Posteriorly Located Renal Pelvis in Ptosis."

Dr. Lloyd H. Mousel, Clinical Professor in Anesthesiology at George Washington University School of Medicine, was the guest speaker at the monthly medical staff meeting at Mt. Alto Veterans Administration Hospital, December 2. Dr. Mousel, who serves on a consultant basis as Branch Section Chief in Anesthesiology for VA's Richmond Branch area, presented a paper entitled "Diagnostic and Therapeutic Nerve Block."

IMPORTANT NOTICE

Ciba Pharmaceutical Products, Inc. wishes to notify all physicians immediately that the Medical Slyd-Rul enclosed in the December issue of *Ciba Symposia* contained a manufacturer's error in placement of decimal point. Conversion from 0.4 grain to gram is incorrect. It should read 0.025 gram, not 0.25. Please make correction by replacing present celluloid table with corrected temporary paper table now being mailed to you. Ciba deeply regrets this error and will replace the temporary slide with a new celluloid table as soon as possible.

Dr. James A. Gannon gave the second in a series of 13 weekly lectures to acquaint practical and undergraduate nurses with their prospective duties. The lecture was given at Central High School, December 9.

Dr. G. Roland Gable has been named physician-in-charge of the District Health Department's venereal disease clinic at Southwest Health Center. Dr. Gable, who has served part-time at the Center since 1933, will replace **Dr. George Creswell,** who has resigned to devote full time to private practice.

Dr. John R. Cavanagh was recently elected to membership in the American Society for Research in Psychosomatic Problems.

Dr. Jacob J. Weinstein attended the Pan American Medical Congress at the University of Havana, Cuba, December 3–8, 1946. He read two papers before the Congress, one on "Etiology, Pathologic Physiology, Clinical Manifestations, Recognition and Correction of Protein Deficiency in Medical and Surgical Diseases," and the other on "The Use of Oral and Parenteral Protein Hydrolysate in Medical and Surgical Diseases." He also presented a scientific exhibit on the subject of "Protein Metabolism and Parenteral Protein Hydrolysate in Surgery."

Dr. Lawrence E. Putnam has been certified by the American Board of Internal Medicine.

The Veterans Administration has announced that all units of the outpatient medical clinic for District area ex-service men have been transferred from Mt. Alto Hospital to the VA Regional Headquarters, 1825 H Street, N.W.

HOSPITAL STAFF MEETINGS

Hospital	*Day of Month*	*Time*
Arlington	1st Thursday	8:00 p.m.
(Meetings held at County Health Dept., 1800 N. Edison St.)		
Casualty	1st Thursday	1:15 p.m.
Children's	1st Monday	1:00 p.m.
Columbia	2nd Friday	8:30 p.m.
Doctors	1st Monday	8:30 p.m.
Emergency	4th Tuesday	12:00 m.
Episcopal Eye, Ear and Throat	1st Friday	8:15 p.m.
Freedmen's	Last Friday	11:00 a.m.
Gallinger	2nd Thursday	11:30 a.m.
Garfield	1st Wednesday*	12:00 m.
George Washington	1st Monday after 1st Tuesday	12:15 p.m.
(Meetings held at 1335 H St., Hall A)		
Georgetown	2nd Monday	12:00 m.
(Meetings held at 36th St. and Prospect Ave.)		
Glenn Dale	Every Thursday	1:00 p.m.
Homeopathic	3rd Tuesday	1:00 p.m.
Mount Alto	1st Monday	8:15 p.m.
Naval	Every Friday	1:30 p.m.
Prince Georges	3rd Tuesday	8:30 p.m.
	Last Sunday	11:00 a.m.
Providence	2nd Tuesday	9:00 p.m.
	3rd Tuesday	11:30 a.m.
Saint Elizabeths	Every Tuesday	11:30 a.m.
(Meetings held at Blackburn Laboratory)		
Sibley	2nd Tuesday	11:00 a.m.
Suburban	2nd Tuesday	8:30 p.m.
Walter Reed	Every Saturday	11:00 a.m.
Washington Sanitarium	3rd Monday	8:00 p.m.

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* February, May, October and December.

NOTE: Except where indicated the meetings are held at the hospital.

MEETINGS

Wednesday, February 12

The Section on Gastroenterology will present the program. The speaker will be BURRILL B. CROHN, M.D., F.A.C.P., Associate in Medicine, Columbia University College of Physicians and Surgeons and Mount Sinai Hospital; Associate Editor, *American Journal of Digestive Diseases and Nutrition*; and Past President of the American Gastroenterological Association. His subject will be "The Management of Ulcerative Colitis."

Wednesday, February 26

SYMPOSIUM ON PLASTIC SURGERY

Several members of the Society will participate in this Symposium. ROBERT E MORAN. M.D., will preside as moderator.

CARDEN FREDERICK WARNER, M.D.

(1862–1946)

Dr. Carden F. Warner, specialist in ophthalmology and otolaryngology, and a Washington resident for many years, died December 5, 1946, at his home, 1870 Wyoming Avenue, N.W., after an illness of several months.

Dr. Warner was born in Philadelphia, Penna., May 27, 1882. He attended Haverford College Grammar School, and graduated in medicine from Hahnemann Medical College, Philadelphia, in 1904. Postgraduate study in eye, ear, nose and throat was pursued by him in Vienna in 1907 and 1908, and in London in 1909.

In 1906, following his internship at the National Homeopathic Hospital. he began the private practice of medicine in the District of Columbia. He maintained his office at 1103 16th Street, N.W. Since 1909 he had been a staff member of National Homeopathic Hospital.

Dr. Warner was elected to Active membership in the Medical Society of the District of Columbia in 1935. He was a Fellow of the American Medical Association, Past President of the District Homeopathic Society, a member of the American Institute of Homeopathy and of the Chevy Chase Club.

Surviving are his wife, Mrs. Emma Philpitt Warner, whom he married in 1945, and three daughters by a former wife, Mrs. Eliza Mitchell Warner, who died in 1940. They are Mrs. E. E. Hamilton of Poolesville, Md., Mrs. Hugh Gregg of Nashua, N. H., and Miss Julia Gross Warner of Washington.

MEDICAL SOCIETIES WITH LIMITED MEMBERSHIP

WASHINGTON, D. C.

1946–1947

SOCIETY	PRESIDENT	SECRETARY	NO. MEETINGS PER YEAR	DATE OF MEETINGS	PLACE OF MEETINGS
Baltimore-Washington Dermatological	M. Sullivan, Baltimore	L. B. McCaleb, Washington	8	3rd Thursday	Alternating Cities
Clinico-Pathological	J. Minor	T. J. Abernethy	8	3rd Tuesday	
Georgetown Clinical	M. J. McInerney	H. H. Hussey	7	3rd Tuesday	Hotel Statler
Georgetown University Medical Alumni Club	T. F. Keliher	R. C. Rush	3	On call	
George Washington University	J. B. Glenn	O. B. Hunter	7	3rd Saturday	School of Medicine
Hippocrates-Galen	G. K. Nutting	G. T. Sharp	5	On call	
International Medical Club	G. C. Birdsall	F. A. J. Geier	4	On call	
Jacobi	B. Golden	L. Gerber	7	4th Monday	
Kober	D. S. Knowlton	J. L. Gilbert	8	3rd Monday	
Mackall	J. E. Wissler	L. B. Gaffney	8	3rd Thursday	
Medical Arts Society*					
Osler	R. M. Page	J. L. Parks	8	3rd Monday	
Pan American (D. C. Branch)	W. Overholser	F. A. Reuter	4	On call	Roger-Smith Hotel
Physician-Veterans of World War II	W. W. Sager	S. W. Hawken		On call	
Rheumatism	D. C. Crain	M. C. Cobey	3	On call	Medical Society Building
Saint Elizabeths Hospital	G. D. Weickhardt	M. Kleinerman	3	On call	St. Elizabeths Hospital
Washington Academy of Medicine	M. W. Perry	E. C. Albritton	3	On call	Roger-Smith Hotel
Washington Academy of Surgery	B. F. Dean	V. M. Hess	4	2nd Friday Oct., Nov., Dec., Apr.	Hotel Statler
Washington-Baltimore Psychoanalytic	B. Weininger	R. Buxton	8	2nd Saturday	Medical Society Building
Washington Gynecological	L. L. Cockerille	R. T. Holden	5	4th Saturday Oct., Nov., Jan., Mar., May	
Washington Heart	F. S. Horvath	B. J. Walsh		On call	Assn. Hdqrs.
Washington Medical and Surgical	G. H. McLain	L. B. Gaffney	3	4th Monday Oct., Jan., Mar.	Hotel Statler
Washington Ophthalmological	R. W. Wilkinson	J. A. Sansoucy	4	1st Monday Nov., Jan., Mar., May	Medical Society Building
Washington Orthopedic Club	F. M. Hand	M. Mendelsohn	7	2nd Monday	Medical Society Building
Washington Society of Pathologists	K. M. Endicott	R. A. Sloan	7	1st Saturday	Army Institute of Pathology
Washington Urological	H. A. Fowler	C. E. Bagley	7	Every 6 weeks	Doctors Hospital
Women's Medical	G. G. Purse	C. L. Fusfeld	9	1st Tuesday	Doctors Hospital

*Reorganization pending.

NOTE: Most of these societies begin their regular meetings in October and continue through April or May. The Editorial Board would appreciate information regarding any additional medical societies not shown on this list.

Peace through Science—Waitt

(*Continued from page 5*)

These are only a few highlights of the contributions. There are many more.

There is no time to talk of our work on rodent and insect control; of fumigation and soil treatment; of the progress made in protecting fruit crops from frost; or of work that we have done in beating so many of our military equipment swords into useful civilian plowshares. Even our deadly flame throwers and tremendously effective incendiaries are finding valuable peacetime uses. All of these things developed for war are now returning peacetime dividends to you.

Perhaps more than anything else, by releasing our scientific information to the public, the Army is laying the groundwork for peace. We are helping to make life easier and better. We are showing our good faith by releasing to science and industry all discoveries that can possibly be released without injury to our national security.

Yes, I believe that eventually world peace will be won through science. It will be won by bringing security, comfort, happiness and health to people everywhere. It will be won not by leveling down, but by leveling up. I'm hopeful that science eventually will accomplish this.

But until that time comes, and unity is brought to mankind, we must maintain the peace by using every possible scientific development to provide us with the most powerful means of national defense available. While we work to make the world a better place to live in and to provide all peoples with a better life, we must defend our own good life. We cannot let anyone take this away from us. We must insist on a research and development program for our Army and Navy that will guarantee us the best equipped and best trained national defense force in the world. Science can assure this.

Pilonidal Disease—Young

(*Continued from page 9*)

4. Faulty postoperative care is often responsible for failure to heal in otherwise satisfactory operations.

5. Incision and drainage combined with proper postoperative treatment will bring about a cure in a large percentage of pilonidal abscesses.

6. The majority of cases require some type of more extensive operation. Of these, the open type of unroofing operation is most satisfactory because:

A. The operative procedure is simple.
B. Patients become ambulatory early.
C. The postoperative discomfort is minimal.
D. The number of sick days is reduced.
E. The rate of recurrence is small.

7. Penicillin and tyrothricine applied topically do not alter the convalescence or reduce the number of sick days.

1801 K Street, N.W.

Streptomycin for Gonorrhea—Putnam et al.

(*Continued from page 14*)

2. Streptomycin appears to be a satisfactory substitute for penicillin in the treatment of gonorrhea.

BIBLIOGRAPHY

1. Miller, C. P., and Bohnhoff, M.: Streptomycin resistance of gonococci and meningococci. J. A. M. A., 1946, **130**, 485.
2. Mortara, F., and Saito, M. T.: Sensitivity of Neisseria gonorrhoeae to streptomycin in vitro. Ven. Dis. Inform., 1946, **27**, 152.
3. Chinn, B. D., and Gillick, F. G.: Outpatient penicillin therapy of gonorrhea. M. Ann. District of Columbia, 1945, **14**, 407.

Footnotes—Observer

(*Continued from Page 35*)

Herbst has been asked to inform members of the Society that the Washington Kiwanis Club has come to the assistance of "The Pines," a convalescent hospital for crippled children at Berkeley Springs, West Virginia. Sponsored by the Kiwanis Club of Morgan County, West Virginia, it has been in operation since 1934. Recently, its patient load has been so light that the institution has not been self-supporting. Mr. William F. Nelson, President of the local Club, writes the Society's President, "We want all our doctors to know that the institution has marvelous facilities for caring for some sixty convalescent patients, it has excellent personnel, a most capable superintendent, Mrs. Velma T. Rice, it has a school which is adapted to each individual's needs, it has an indoor pool for under-water therapy, and it has access to the spring waters of Berkeley Springs which chemical analysis indicates are almost identical with those of Warm Springs, Georgia." Mr. Nelson urges Washington doctors to send their convalescent patients to "The Pines," the rates being low for value received. Adults, he says, can also be accommodated.

T. W.

Swanson Succeeds McIntire

(*Continued from page 39*)

Hospital Association, and the Association of Military Surgeons.

As Surgeon General of the Navy he directed the planning for the expansion of the Medical Department in the present national emergency. It was necessary to maintain and expand research in various branches of naval medicine in order to keep abreast of the rapidly changing developments brought on by the War. In addition to these duties he continued as physician to the White House and personal physician to President Roosevelt.

Admiral McIntire has received honorary degrees from George Washington, Tulane, Marquette, Syracuse, Willamette and Georgetown Universities. In January 1946 he received the Navy's Distinguished Service Medal for his services as Chief of the Bureau of Medicine and Surgery and Surgeon General of the U. S. Navy. He has been decorated by the following foreign governments: Brazil, Sweden, Belgium, France, Luxemburg, Denmark, Poland, Nicaragua, Norway, French Morocco and Great Britain.

Washington Physicians of Yesterday—King

(*Continued from poge 40*)

Dr. King was present at the assassination of President Lincoln in 1865 and was one of the physicians who rendered first aid; supporting the left shoulder, he assisted in carrying the wounded patient from Ford's Theater across Tenth Street to the Peterson house, where he expired.

Dr. King had an interesting and colorful personality, well remembered by his former contemporaries who are still living. He was a prolific contributor to medical literature, his bibliography including more than eighty titles; he had an ingenious mind, and was the author of many striking expressions and papers. For instance, in one paper, reverting to the defecatory habits and facilities of primitive peoples, he deduced the proposition "For constipation, squat." While some of his ingenious speculations were not taken very seriously, he scored one notable hit over the doubters in a paper published in 1883 in which he presented the theory that malaria is transmitted by mosquitoes, thus anticipating by many years the scientific demonstration of that fact.

The proceedings of the Medical Society during its existence preceding the election of Dr. King as its Secretary in 1865 had been rather routine and perfunctory; but with his accession a group of kindred spirits greatly amplified its activities by introducing weekly meetings for the presentation of scientific papers. The change is indicated by the scope of the records; 169 pages of the minutes covered the proceedings of the Society for the preceding 27 years (1838–1864), while 161 pages were required to record the transactions of the succeeding 17 months in 1865–66. Dr. King was a major influence in bringing the Medical Society up to its present scientific and professional status.

John B. Nichols, M.D.

MEDICAL ANNALS
of the
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VOLUME XVI *February, 1947* NUMBER 2

RECENT ADVANCES IN PEDIATRICS

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Lieutenant (junior grade), Medical Corps, United States Naval Reserve

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Chief of Medical Staff, Children's Hospital

A COMPREHENSIVE survey of the newer advances in the field of pediatrics would be quite beyond the scope of this report. A few representative topics have been selected for discussion and will be reviewed briefly.

CONGENITAL DEFECTS FOLLOWING GERMAN MEASLES

At the present time attention is being directed toward the virus exanthemata as causes of congenital defects when they occur in the mother during the early months of pregnancy.

The earliest observations were made by Gregg[1] of Australia in 1941 who reported a series of 78 cases of congenital cataracts occurring in babies whose mothers had suffered from an exanthematous disease diagnosed as rubella during the early stages of pregnancy. In 44 of these cases congenital lesions of the heart were also detected.

In 1943, Swan[2] and his co-workers reported the results of their investigations confirming Gregg's findings. A total of 49 cases with rubella were reported as having occurred during the early stages of pregnancy. All of the 25 cases occurring during the first 2 months of pregnancy showed some congenital defect in the infant most frequently involving the heart or the eyes. When the disease occurred in the third month 4 out of 8 showed defects. Only 2 out of the 16 showed defects when the disease occurred after the third month of pregnancy. Of the total 31 defects, 17 were of the heart, 14 of the eyes, 7 were deaf mutes, and Mongolian idiocy, microcephaly, hypospadias and mental retardation were each present in several cases.

Reese[3] was the first investigator in this country to lend confirmation to the Australian observations. This author reported 3 cases of congenital cataracts in infants whose mothers had rubella in early pregnancy. Rones[4] added 4 more cases of ocular defects in which the mothers had an exanthematous disease in the early months of pregnancy. Erickson[5] in 1944 reported 11 additional cases, and the majority of these infants showed cardiac findings which were suggestive of an interventricular septal defect.

Conte et al,[6] in summarizing the literature to date, discuss 136 cases of congenital anomalies which have been reported in the literature in which a definite history of virus infection in the mother during pregnancy had been obtained. In all but 2 of these cases the offending virus had been rubella, which occurred before the third month of pregnancy, with the exception of 3 cases in which the disease occurred in the 4th, 5th and 6th month. The congenital anomalies described in these cases were varied. In a total of 136 cases, 80 per cent of the offspring had either unilateral or bilateral cataracts; 62 per cent were found to be mentally deficient; 57 per cent were found to have heart disease; 54 per cent of the total were found to have a combinaton of cataracts and heart disease. Twenty additional cases of maternal rubella without congenital malformations in the infant have been reported. In 4 of these rubella occurred in the third month of pregnancy, and in the remaining 16 cases it occurred in the second trimester. Conte and his associates[6] then reviewed all cases of diagnosed congenital heart disease, congenital cataracts, microphthalmus, deafmutism, hydrocephalus, and Mongolism seen at the University Hospital at Vanderbilt during the 5-year period from 1939 to 1944, and found that maternal rubella was noted in 4.2 per cent of the 61 cases of congenital abnormalities surveyed. This was stated to exceed by at least 10 times the actual case rate of maternal rubella found during the child-bearing age group in the population at large.

The abnormalities folowing rubella in the early months of pregnancy follow no definite pattern. The fact that the eye and heart defects occur most frequently is difficult to explain. Erickson[5] attempts to correlate these findings with the development of these organs at this period, i.e., at the 7th and 8th weeks. However, during this same period the jaw, palate, mouth and other structures are being formed and the cerebral vessels and the choroid plexuses are being laid down. Yet cleft palate, harelip and hydrocephalus, all common congenital anomalies, have not been reported to occur with any greater frequency than that due to chance following rubella in pregnancy.

The advisability of inducing a therapeutic abortion when rubella occurs during the first trimester of pregnancy cannot be answered at the present time. From the available data any categorical statement justifying interruption of pregnancy would be premature, since the frequency of congenital defects following rubella in the first trimester has not been definitely estimated thus far because of inadequate study. Most of the investigators have based their conclusions on individual records and have failed to cite the total number of women having rubella in pregnancy with no congenital defects in the offspring. Fox and Bortin,[7] adopting this latter approach, examined the records of the city of the Milwaukee Public Health Department and surveyed 22,226 cases of German measles covering a period from 1942 to 1944 inclusive. Of these, 11 were pregnant at the time they had rubella; in 5 the disease occurred during the first 2 months, in 4 during the 2nd to 4th months, and in the other 2, in the 7th and 9th months respectively. In only 1 case (9.09 per cent) was there evidence of either a coincident or direct involvement resulting from rubella. This is to be contrasted with Swan's conclusion[2] that all mothers with such exanthemata during the first 2 months of pregnancy will give birth to children with congenital abnormalities. Similar comprehensive surveys with a public health approach should be done in an effort to determine more precisely the approximate incidence of congenital defects following rubella. This would be mandatory before one would be justified in blandly accepting the Cassandra-like admonishments of those who would advise routine therapeutic abortions when the disease occurs in the first trimester of pregnancy.

It is well to realize that rubella can no longer be regarded as an inconsequential disease. Careful attention to the occurrence of exanthemata during pregnancy should become routine in obstetrical care.

The possibility exists that the products of human blood fractionation might yield a safe and effective agent in prevention and attenuation of rubella as has been already found for rubeola.

RECENT SURGICAL ADVANCES IN CONGENITAL CARDIAC MALFORMATIONS

A. *Tetralogy of Fallot.* One of the commonest malformations of the cyanotic group of cardiac anomalies is the tetralogy of Fallot. Pathologically there are 4 cardinal features characteristic of the condition, including pulmonary stenosis, dextroposition of the aorta, hypertrophy of the right ventricle, and a defect of the interventricular septum. Because the aorta usually overrides the right ventricle and because the blood encounters difficulty in passing through the stenosed pulmonic orifice, part of it is shunted from the right ventricle directly into the systemic circulation causing persistent cyanosis. Only that portion of the blood going through the pulmonary artery receives oxygenation in the lungs, the remaining portion being pumped over and over again in its unoxygenated state out into the systemic circulation as the cycle repeats itself. This of course results in intense cyanosis, since peripheral tissues are deprived of an adequate oxygen supply. Failure to gain weight, marked dyspnea, occasional palpitation, orthopnea, extreme fatigability, and limitation of movement are some of the symptoms encountered. Clubbing of the fingers and toes is nearly always present, and widespread cyanosis is evident.

The diagnosis is as a rule not difficult One can make a tentative diagnosis of the tetralogy of Fallot in most cyanotic infants with a loud, harsh systolic murmur heard best over the second and third left interspace. The roentgenograms of the heart usually are of diagnostic aid, revealing a typical cardiac contour rather appropriately termed cor en sabot (or wooden shoe). Convulsions or periods of unconsciousness followed by hemiplegia are not infrequent. During the past 2 years we have seen 3 cases of the tetralogy of Fallot at Children's Hospital who have had definite residual and persisting hemiplegia associated with the cardiac anomaly. The unconsciousness and hemiplegia are probably the result of cerebral ischemia or thrombosis of the smaller vessels due to sluggish blood flow; polycythemia is probably less prominent as an etiologic factor, since it was present in only 1 of the 3 cases.

Within recent months Blalock and Taussig[8] have succeeded in devising an operation, compensatory in nature, which very definitely mitigates the severity of the symptomatology encountered in the tetralogy of Fallot. These investigators hypothesized that if a shunt could be made surgically, a greater volume of blood might be diverted to the lungs for oxygenation, the systemic circulatory tissue respiration benefiting thereby. Experimental work on animals led to the conclusion that the establishment of a larger flow of blood to the lungs would insure a marked increase in arterial oxygen which was considered the most important single factor. Accordingly an operation was devised whereby an anastomosis of the large trunk arteries of the aorta to another branch of the main pulmonary artery was accomplished. First and most readily performed was an anastomosis between the end of a systemic artery such as the subclavian and the side of the left pulmonary artery. However, the extremely small size of the subclavian artery in infants militates somewhat against the success of this method because of the danger of thrombosis at the operative stoma, especially when there is an associated polycythemia. A second approach was the anastomosis of the innominate artery to the side of the left pulmonary artery.

In May 1945, these investigators[8] reported 3 cases in which this short-circuiting operation had been successfully performed. Postoperatively the children improved considerably with a marked diminution in the degree of cyanosis and a definite increase in the amount of work that the patients were able to perform. Similarly it was noted that the oxygen saturation percentage increased considerably after operation, reaching 83 volumes per cent after 30 days. This would indicate an increased efficiency in the CO_2–O_2 interchange in the lung, with the hemoglobin reaching almost its complete saturation point. In effect this operation consisted of the creation of an artificial ductus arteriosus.

Since this preliminary report appeared, approximately 100 additional cases have been operated on by the Blalock technic with about a 20 per cent fatality rate. Taussig[9] states that the operation is considerably more hazardous in infants than in older children and raises the question as to what will happen to the anastomosis with the growth of the child. For that reason she is opposed to operation in early infancy unless the anomaly is almost certainly destined to be fatal without surgery. Taussig does not believe that the operation is indicated under 2 years of age, and in her opinion the ideal age is between 7 and 10 years.

B. *Patent Ductus Arteriosus.* In 1938 Gross[10] performed the first successful ligation of a patent ductus, and since that time approximately 400 ligations have been performed in this country with considerable success, the mortality ranging between 5 to 10 per cent. Touroff[11] was the first to actually sever the duct, and more recently Gross[12] has reported a series of 54 cases in which the last 14 cases had the ductus severed, with uniformly good results. Davis[13] has had a series of 25 cases of patent ductus with no operative mortality.

The principal complications of patent ductus include physical retardation (in about 35 per cent) due to the diminution in peripheral distribution of the blood, the possibility of cardiac failure due to the added burden thrown on the heart, and the danger of a superimposed streptococcal viridans infection. Of these 3 complications the first is apt to manifest itself in childhood, while the second and third rarely occur before adolescence or early adult life.

In selecting patients for operation, careful study should be made of each individual case. An associated congenital anomaly of the heart or great vessels to which the ductus is a compensatory mechanism must necessarily preclude operation. In this regard, children with cyanosis and clubbing of the fingers do not have uncomplicated patent ductus and are not candidates for surgery. On the other hand, all patients who possess an uncomplicated patent ductus arteriosus are not necessarily subjects for operation. When an individual reaches the age of 45 years without complication of his ductus, surgery should rarely be considered advisable. However, the opinion that all children with a patent ductus (irrespective of the presence or absence of symptoms of subacute bacterial endocarditis) should be operated on is gaining wider acceptance. Regarding optimal age, it is more or less generally agreed that patients over 5 years of age are the most suitable candidates for ligation of a ductus, since in children under this age the small size of the structures and the fact that some cases are associated with coexisting anomalies make operation less advisable.

The best single criterion for the diagnosis of patent ductus is the murmur, which is typically a loud blowing continuous one with systolic accentuation, the term "machinery" murmur being quite descriptive. The murmur is transmitted over the precordium, and it is most intense over the 2nd and 3rd interspaces just to the left of the sternum. A thrill is palpable in over one half of the cases and is most prominent in the pulmonic area. Rarely the murmur may by systolic alone, although this as a rule occurs only in children under 3 years of age; beyond this age the murmur is both systolic and diastolic. In an uncomplicated patent ductus, the electrocardiogram is usually within normal limits; pronounced right or left axis deviation casts doubt on the correctness of the diagnosis. X-ray observation of the heart, pulmonary artery and hilar vessels (for hilar dance, etc.), while adding some confirmatory evidence, is not necessarily conclusive and occupies a position of secondary importance in helping to make the diagnosis.

C. *Coarctation of the Aorta.* This anomaly is characterized by a narrowing or complete obstruction of the aorta at or near the ductus arteriosus or its obliterated remnant, usually in the arch beyond the point where the carotids and the subclavian artery branch. The blood supply to the arms and head is thus unimpaired and the blood pressure in the upper extremities is higher than normal. Because the blood supply to the legs, trunk and viscera is reduced, the pressure in the lower extremities is of considerable diagnostic importance. Erosion of the lower borders of the ribs is due to increased pressure produced by enlarged intercostal arteries which act as collaterals; this osseous change, which is readily seen on X-ray films, usually does not occur before the 4th year.

This abnormality is not necessarily incompatible with longevity, but the majority of patients die early because of rupture of the aorta, dissecting aneurysm, aneurysmal dilatation of the aorta proximal to the constriction, congestive failure, or subacute bacterial endocarditis.

Gross[14] proved that it was technically feasible to remove surgically segments of the thoracic aorta in experimental animals and to reconstruct the vessel by end-to-end anastomosis. Recently he reported 5 cases in humans in which this operation has been performed; the first patient died of cardiac failure during operation, but the other 4 have made satisfactory recoveries.

D. *Persistent Right Aortic Arch.* This constitutes an anomaly which only recently has received any diagnostic consideration. It is produced, as the name implies, by an aberrant course of the aorta, the latter curving to the right rather than the left and passing behind the esophagus. It may produce pressure symptoms on the trachea and esophagus resulting in dysphagia and obstructive breathing especially when accompanied by a vestigial left aortic arch which, together with the right arch, may produce a constricting vascular ring. Faber[15] has recently described 4 cases.

The diagnosis is made by visualizing the forward displacement and filling defect in the barium-filled esophagus at the level of the aortic arch. In addition, the aortic knob is seen to the right of the esophagus.

Its principal current interest has been the demonstration by Gross[16] that it is an operable anomaly. He recently reported a case in which the rudimentary left aortic arch and ligamentum arteriosum were divided to relieve marked constricting pressure symptoms in an infant.

PROPHYLAXIS IN RHEUMATIC FEVER

The importance of rheumatic fever in the pediatric age group needs no elaboration here. Suffice it to say about 250,000 cases occur in the United States each year and that there are from 30,000 to 60,000 yearly fatalities from rheumatic heart disease, making it the leading cause of death up to the age of 21 years. In New York City alone in the year 1938 there were 1,105 deaths from rheumatic fever, and during the same period there were only 247 deaths from pertussis, diphtheria, measles, scarlet fever, meningococcal meningitis, and poliomyelitis combined. Rheumatic fever thus claimed 5 times the combined total of 6 common childhood diseases. In view of this, mention should be made of the recent encouraging reports regarding the effectiveness of prophylaxis of rheumatic fever. It might be said that the problem of prophylaxis in the light of our present knowledge regarding the etiology resolves itself into the prophylaxis of beta hemolytic streptococcal infections of the upper respiratory tract.

Since attacks of tonsillitis and pharyngitis due to Group A hemolytic streptococci precipitate rheumatic fever recurrences, the advent of sulfonamides offered some possibility of control. In 1939 Coburn and Moore[17] treated 80 rheumatic patients with 2 grams of sulfanilamide daily during the winter and spring season and noted that only 1 patient developed a hemolytic streptococcal infection with signs of rheumatic activity. The same year Thomas and France[18] discussed the dividing up of 60 rheumatic patients into 2 equal groups. To group 1 they gave 1 to 1.5 grams of sulfanilamide a day for the winter and spring season. Group 2 served as a control. In the treated group there were no major rheumatic attacks during the period studied, whereas in the control group, 2 major, 5 minor and 3 questionable rheumatic attacks occurred. In 1940 Coburn and Moore,[19] in a review of 184 rheumatic subjects who received sulfanilamide prophylactically, recorded an incidence of attacks of 1 per cent, whereas the usual rate is computed as 35 per cent. Kuttner and Ryersbach,[20] during the winters of 1940–1941 and 1941–1942, had 108 rheumatic children divided into 2 groups closely matched as to age, sex, number of previous rheumatic attacks and cardiac findings. Of the control group of 54, 14 had definite rheumatic recurrences and 4 had questionable rheumatic recurrences, whereas in the sulfanilamide-treated group of 54, only 1 patient had a rheumatic attack.

In 1941 Thomas et al[21] reported a series of 55 patients receiving sulfanilamide prophylactically. There were no major attacks of rheumatic fever. Of 67 controls there were 15 major attacks.

In an 8-year survey, from 1938 to 1944, Fullerton[22] reported on 815 rheumatic patients given sulfanilamide and recently sulfadiazine with a recurrence rate of only 1 per cent, whereas in the control series 10 to 35 per cent developed rheumatic fever. He also mentions the project carried on by the Navy in 1943. Two hundred and fifty thousand men received 0.5 gram of sulfadiazine twice a day. Hospitalization for severe respiratory diseases was reduced 80 to 90 per cent, and for streptococcal infections 85 per cent. In a control group of 250,000 men there were 14 cases of rheumatic fever for every 1 case in the treated group. The conclusion seems warranted that the therapeutic value of the sulfonamides so far outweighs the possible minor toxic reaction that failure to utilize the drug for fear of toxicity does not seem to be justified.

In view of the fact that leukopenia is a possibility (although a remote one) every patient receiving sulfadiazine prophylactically should have frequent leukocyte counts and hemoglobin determinations. It should be emphasized that every child who has had an attack of rheumatic fever is a candidate for a second and third attack. The best method for preventing these recurrences is to prevent attacks of upper respiratory infection with hemolytic streptococcus. Since the greatest incidence for these infections is from October to June, it would seem wise to administer sulfadiazine to these children during those months. An adequate daily dose consists of 1 gram daily given in 1 dose or 2 equally divided doses. Care of this sort is necessary for almost 2 decades until the natural susceptibility to rheumatic fever disappears. With an intelligently administered program of this sort much can be done to reduce the incidence of rheumatic recurrences.

HISTOPLASMOSIS

Histoplasmosis is a mycotic infection caused by Histoplasma capsulatum which grows as a small yeast-like organism in the reticuloendothelial cells, tissue endothelial cells and the blood and marrow mononuclear cells. In a recent report[23] from Children's Hospital, 4 cases of histoplasmosis were described; 2 of the cases occurred in brothers and represented the first reported instance of histoplasmosis in siblings. All 4 patients were children living in Loudoun County, Virginia, within an area having a radius of 8 miles, suggesting that there may be in this area an unusual geographical concentration of the mycosis.

In Darling's original report[24] he described the disease as being characterized by splenomegaly, emaciation and prolonged intermittent fever. Subsequent reports have shown considerable variation in the symptomatology and the physical findings. In their comprehensive summary report, Parsons and Zarafonetis[25] found an irregular temperature to be an almost constant feature, although normal temperature in rare cases may be present during periods of remission. Anemia, hepatomegaly, splenomegaly and lymphadenopathy are present in the majority of patients, while leukopenia, gastrointestinal symptoms, emaciation, and ulcerations of the mouth and buccal cavity are present in approximately one third to one half of the cases reported.

The inconsistency of the presenting symptoms and the fact that it simulates several other diseases make the clinical diagnosis of. histoplasmosis relatively impossible. In view of its protean manifestations the disease may readily be confused with aleukemic leukemia, Hodgkin's disease, lymphosarcoma, tuberculous adenitis, kala azar, brucellosis and infectious mononucleosis.

The diagnosis of histoplasmosis can be established only by the laboratory demonstration of the fungus. Examination of blood smears is not too reliable a diagnostic criterion, since the fungus is present in the circulating blood only intermittently or in very small numbers or terminally. Bone-marrow aspiration and/or biopsies of lymph nodes, spleen and material from the ulcerations probably constitute the most reliable methods of establishing a diagnosis of histoplasmosis.

The source of infection and the mode of transmission of histoplasmosis is not known. Sporadic appearance of the mycosis without recognized association between cases of infection could be interpreted to indicate that it is not primarily a human disease and is not dependent upon an unbroken chain of human infections or human carriers. The possible occurrence of some animal host or reservior should be considered. The disease may have an acute onset and terminate rapidly, or it may appear in chronic form with irregular exacerbations and long remissions.

Regarding treatment, Neostam (Stibium glucoside) and antimony compounds have been used in some cases with equivocal results. The occasional encouraging outcome with Neostam would indicate that it warrants further trial. Roentgen therapy has also been used in histoplasmosis; however, the effect is only palliative and does not seem to alter the course of the disease.

The significance of the histoplasmin skin test has recently aroused considerable interest. The desirability of having a specific cutaneous test to detect histoplasmosis is apparent, since it would not only aid in diagnosis but would also detect healed or arrested infections. Palmer,[26] investigating the possibility that an infection with Histoplasma capsulatum is the cause of non-tuberculous pulmonary calcifications, concludes from his studies that histoplasmosis or an immunologically related fungus may account for the presence of pulmonary calcifications in tuberculin-negative reactors. A corollary of this would be that histoplasmosis in a benign form may be quite prevalent, at least in the central and eastern half of the United States. Emmons, Olson and Eldridge[27] have demonstrated, however, that histoplasmin is not specific in histoplasmosis but shows cross reactions with blastomycosis, coccidiomycosis, haplomycosis and Candida albicans, and these investigators conclude that histoplasmin used in skin-testing is not a specific diagnostic antigen. In the 2 cases of histoplasmosis which occurred in siblings here at Children's Hospital, both patients were tested with histoplasmin in dilutions ranging from 1:1000, 1:100, 1:10 and undiluted, and in both the skin test was negative in all dilutions. It seems probable that these patients were anergic, since they were in the terminal stage of the infection when tested. An analogous situation might be the negative tuberculin reaction not infrequently seen in overwhelming tuberculous infections.

In a recent study at Children's Hospital, 440 ward cases were skin-tested with histoplasmin (1:1000) in a preliminary attempt to determine the age incidence and distribution of histoplasmin sensitivity among children residing for the most part in the District of Columbia and surrounding areas. Of these, 16 children (3.6 per cent of the total number) showed a positive reaction, and with 3 exceptions all the histoplasmin-sensitive patients were found to have parenchymal and hilar pulmonary calcifications on X-ray examination. Only 2 of these 16 patients had positive tuberculin tests. The incidence of histoplasmin sensitivity was found to increase with age. This is in essential agreement with the results of Christie and Peterson[28] who also found a rapid increase in sensitization in the older age groups.

Erythroblastosis Fetalis

Erythroblastosis is a sequel of the sensitization of an Rh negative mother to Rh positive red blood cells with the development in the mother's serum of anti-Rh agglutinins. The latter are able to pass the placental barrier and produce hemolysis of the red cells of the Rh positive infant resulting in erythroblastosis fetalis.

About 87 per cent of the white population are Rh positive, of the colored population from 92 to 95 per cent. The higher percentage of Rh positivity in the negro is reflected in the relatively low incidence of erythroblastosis in colored infants. Of the 29 cases of erythroblastosis admitted to Children's Hospital during the past 10 years, 27 were white and only 2 were colored. In view of the fact that 13 per cent of the white population are Rh negative one might hypothetically expect erythroblastosis to occur in approximately 1 out of every 13 newborns; however, the actual incidence more nearly approaches 1 in every 200 infants, because several factors are operative. In the first place, more than 1 pregnancy is usually necessary to produce an erythroblastotic infant in view of the fact that the first pregnancy only initiates sensitization and a second or subsequent pregnancy is required to produce a higher titer of anti-Rh agglutinins. Secondly, about one half of the Rh positive male population are heterozygous and may thus produce Rh negative children. An additionalf actor would be the impermeability of the intact placental barrier to the passage of red cells.

The diagnosis is clinically inferred from the presence of jaundice (usually developing within 24 hours after birth), anemia, hepatosplenomegaly, and nucleated red cells in the peripheral blood. Not all of these clinical manifestations are necessarily in evidence, however; the laboratory demonstration of an Rh positive father, an Rh negative multiparous mother, an Rh positive infant and the presence of an anti-Rh titer in the mother's serum is confirmatory. Other causes of jaundice in the neonatal period include physiologic icterus, sepsis, congenital syphilis, and biliary atresia; these entities are as a rule readily differentiated from erythroblastosis fetalis.

Regarding therapy, it is necessary to transfuse an erythroblastotic infant with compatible Rh negative blood as soon as possible postpartum. A single transfusion should not exceed 10 c.c. per pound of body weight. In the majority of instances 2 or 3 transfusions within the first week will suffice; on occasion, however, additional transfusions will be required. The scalp and the external jugular veins are usually the most readily accessible for transfusions in the newborn infant; infrequently an ankle or an antecubital vein can be used. The average pediatrician with considerable experience in intravenous work in the young infant usually encounters no technical difficulty. On occasion exposure of an ankle vein or a bone marrow transfusion is necessary when no veins are available; it is well to point out, however, that bone marrow transfusions are often difficult in an erythroblastotic infant because of the small marrow cavity usually present in these cases. Fontanel transfusions are resorted to only as the last desperate measure and had best be eschewed until all other veins have been tried.

In extenuating circumstances when no Rh negative blood is immediately available, a transfusion with compatible Rh positive blood may be employed as a temporary stop-gap. It is well to bear in mind, however, that the survival time of transfused Rh positive blood cells in an erythroblastotic infant is only about 5 to 7 days, whereas that of Rh negative blood cells approaches 2 to 3 months.[29] This is borne out clinically by the fact that usually 3 times as many transfusions are required when Rh positive blood is employed.

Erythroblastotic infants should be put on formula postpartum in view of the demonstration that the mother's breast milk contains anti-Rh agglutinins which are possibly absorbed in the gastrointestinal tract to produce further hemolysis of the infant's Rh positive red cells.[30]

The question frequently arises as to the prognosis of future pregnancies in a woman who has had a previous infant with erythroblastosis fetalis. A laboratory measurement of some considerable value in these instances is the determination of the anti-Rh titer during pregnancy. If the titer suddenly rises in the third trimester, early induction is indicated if the possibility of obtaining a viable infant is relatively good. This procedure will be of undoubted usefulness in assisting the previously sensitized Rh negative mother to have a living Rh positive infant. Diamond[31] reports 41 cases of early induction of labor in the presence of a rising titer of anti-Rh agglutinins, and of these 32 were living and 9 died.

Erythroblastosis following sensitization produced by the transfusion of an Rh negative woman with Rh positive blood results in the most severe form of this disease. Diamond[31] reported a series of 25 women who had received Rh positive transfusions, and of these 18 had 2 or more infants with erythroblastosis fetalis; of 32 of these fetuses or babies 28 died in utero and 4 lived for less than 24 hours. These infants frequently die in utero in the 7th or 8th month of gestation. A recent case seen at Children's Hospital illustrates this point. A 23-year-old woman received 4 transfusions in 1943 following an operation. She became pregnant for the first time in 1946, and in the 8th month of gestation a sudden rise of anti-Rh titer to 1:256 was noted. It was decided to interrupt the pregnancy with a Caesarean section, and a viable baby was delivered. The infant, however, was in critical condition postpartum. The hemoglobin was 10 grams with 2.4 million red cells, and there were 145 nucleated red cells per 100 white cells; severe icterus was first apparent 6 hours postpartum. The baby was immediately given 75 c.c. of Rh negative type O blood and subsequently received 6 additional small transfusions of Rh negative blood during the course of the next 2 weeks. Recovery was uneventful. The father of this infant was tested and was found to be homozygous Rh positive. Hence, the prospect of obtaining a viable infant in a second pregnancy would be remote indeed and represents in all probability a termination of the childbearing potentialities of this young mother.

At Children's Hospital the policy has been adopted of performing Rh typing on all female infants and children who are scheduled to receive transfusions, and if the patient is Rh negative, Rh negative blood is administered. This is predicated on the assumption that an Rh positive transfusion administered to an Rh negative female patient even in the infant age group may produce initial sensitization which may be restimulated subsequently by pregnancy to produce erythroblastosis when this infant herself reaches the childbearing age. Levine and Waller[32] recently reported a case of an 8-year-old Rh negative child who received Rh positive transfusions, and 14 years later when this child had grown to maturity and had herself become pregnant she gave birth to a severely erythroblastic infant in her first pregnancy. The point seems well established that transfusions of Rh positive blood in an Rh negative female at any time in her life will sensitize her and ultimately affect her first-born child.

FOLIC ACID IN THE TREATMENT OF MACROCYTIC ANEMIA

The newly synthesized L. casei factor (folic acid) has been found to be a specific anti-anemic principle in the presence of anemias of the megaloblastic type. Spies et al[33] have demonstrated the efficacy of folic acid in the various macrocytic anemias of adults including pernicious anemia, nutritional macrocytic anemia, sprue, and the anemia of pregnancy. More recently Zuelzer and Ogden[34] reported on the results obtained with folic acid in 25 infants with megaloblastic anemia. This type of anemia resembles in morphologic patterns the basic features seen in pernicious anemia. Twelve of these were treated with folic acid in synthetic form or by oral administration of concentrates rich in L. casei factor, the dosage varying from 5 to 10 mg. a day, the period of treatment being from 8 days to 3 weeks. An unequivocal response was obtained in the majority of these cases including a substantial rise in reticulocyte count usually starting within 3 or 4 days and terminating within a week; in addition there was a distinct return of the bone marrow to the normal type of erythropoiesis, and this was associated with a consistent rise in red cell count and in hemoglobin values. Zuelzer[35] has demonstrated that folic acid is not effective in any other type of anemia in which the formation of blood by the bone marrow remains normoblastic. Negative results were obtained in the anemia of prematurity, Mediterranean anemia, aplastic anemia, leukemia, sickle-cell anemia and hypochromic microcytic anemia. This investigator concluded that there is a "complete parallelism regarding the response of folic acid between the anemias of infancy and those of adult life."

Present information indicates that the casei factor of folic acid cannot be chemically identified as the intrinsic factor of Minot. As Moore[36] points out, the possibility still exists that it may be related to the extrinsic factor of Castle.

HEMOPHILIA

A new product of plasma fractionation (fraction I), recently developed by Cohn and his collaborators at the Harvard Medical School, has yielded an anti-hemolytic substance. This fraction, which contains 60 per cent of fibrinogen, was used by Minot et al[37] in 16 cases of hemophilia. In 15 of these the intravenous or intramuscular injection of 11.5 to 125 mg. of material of the fraction was followed by a rapid return of the coagulation time to normal. Fibrinogen when used alone had no effect. The possibility remains that daily injections of this fraction may allow a hemophilic patient to maintain his coagulation time at normal values. Further confirmatory work is awaited with interest.

RECENT ADVANCES IN IMMUNIZATION

A. *Pertussis.* Below the age of 1 year whooping cough is one of the most fatal of infectious diseases. Under ordinary circumstances there is abundant clinical proof that no significant resistance to whooping cough is transferred from mother to fetus. In addition, it has been generally accepted until recently that any attempts at active immunization with pertussis vaccine in babies under 6 months of age would be without value because of serologic immaturity of the infant with concomitant inability to manufacture antibodies to any appreciable extent. Thus, there exists a dangerous hiatus extending from the newborn period until 6 months of age during which time the infant is virtually defenseless against pertussis. The desirability of producing an adequate antibody titer during this interval is thus apparent. Two recent approaches to this important problem bear mention.

Cohen and Scadron[38] and Kendrick et al[39] have recently attempted to induce immunity in the newborn infant by administering potent pertussis vaccine to the mother during the third trimester of pregnancy and found that pertussis circulating antibodies do pass through the placenta; these investigators concluded that active immunization of the mother during the third trimester is a feasible method of producing a passive trans-placental immunity in the infant. If this is confirmed by clinical evidence of immunity—and it is well to add that clinical confirmation would be a sine qua non before endorsement of this régime is indicated, it would be an important adjunct in bridging the hazardous first 6 months of neonatal period which is encountered today in prophylaxis against pertussis.

A second approach to the problem has been the reëvaluation of the efficacy of early immunization against pertussis. Sauer,[40] using a plain vaccine prepared from phase I strain of the organism, attempted to inoculate infants under 3 months of age but found that 8.19 per cent of the infants in this age group contracted pertussis as compared to 1.44 to 2.8 per cent of children vaccinated after 7 months of age. From these results this investigator concluded that inoculation against whooping cough before the age of 6 months was ineffective. However, Sako et al[41] used an alum precipitated vaccine on 16,000 infants under 2 months of age and demonstrated that 75 per cent of these infants showed an antibody response measured by the rapid slide agglutination test. Similarly, Waddell and L'Engle,[42] reporting on the prophylactic use of Cutter's pertussis vaccine, started their immunization against pertussis at the age of 1 week with a second dose at 1 month and the third dose at 2 months of age and found a relatively high incidence of positive agglutination tests in high dilutions within the first 6 months. Again, however, until definitive clinical evidence of immunity is forthcoming as judged by actual protection to exposure, it would be well to reserve comment on the efficacy of early immunization. In this regard Lapin[43] cautions against accepting the presence of agglutinins, complement fixation tests, antibodies, and opsonins as a criteria of protective antibodies, since these may not measure immunity. Further investigation on this important aspect of pertussis immunization will be watched with interest.

Alum precipitated vaccines, such as mixtures of H. pertussis and diphtheria toxoid as well as the triple immunization mixture against pertussis, diphtheria and tetanus, have enjoyed a measure of popularity within recent years. However, the relatively high incidence of sterile abscesses (approximately 5 to 10 per cent) at the site of injection neutralizes their advantage in part.

Lapin,[43] attempting to reëvaluate the optimal dose of pertussis vaccine, inoculated 200 infants from 6 to 9 months of age with 120 billion organisms, and the results indicated a communicability rate of only 9.6 per cent as compared with an average of 33.9 per cent for those receiving the customary 80 billion organisms. From his 3-year study this investigator recommends that the concentration of vaccine should be 20 to 40 billion units to the cubic centimeter, with 3 doses given at 4-week intervals for a total dose of 120 billion organisms.

Recent studies by Strean[44] suggest that a new skin-testing technic may be available as a simple index of the immunity to pertussis.

B. *The Use of Gamma Globulin in Immunization.* Gamma globulin is a by-product of plasma fractionation (fraction II) isolated by Cohn and his associates. The concentration of the globulin antibodies in fraction II is 25 times that of the pooled plasma from which it is derived.

During the past 3 years gamma globulin has come into widespread use as a prophylactic agent for the complete protection or attenuation of measles. For complete prevention a dose of 0.1 c.c. per pound of body weight is given intramuscularly as soon as possible after contact, and for attenuation a dose of 0.025 c.c. per pound is administered from the fifth to the tenth day following exposure. The duration of passive immunity following a single dose is approximately 3 weeks. During the past year we have found gamma globulin to be singularly effective in preventing the wholesale spread of measles on the wards at Children's Hospital. Sweet and Hickman[45] recently reported on the prophylactic use of gamma globulin in 241 cases of exposed susceptible children at Gallinger Hospital. Of these, 50 developed a mild or attenuated measles and 7 developed average measles. The only complication in the entire group was 1 case of otitis media. There are few reactions encountered in the use of gamma globulin; Janeway[46] reported an incidence of 1.7 per cent of 1,842 intramuscular injections, one half of which consisted only of local soreness and most of the remainder of slight fever. Gamma globulin is by far the prophylactic agent of choice against measles as compared to convalescent serum, placental globulin extract or normal adult serum in view of its greater effectivity, paucity of untoward reactions, and the smaller volume of material required.

With reference to its value in the prophylaxis of other diseases, Stokes and Neefe[47] recently suggested that infectious hepatitis may be prevented or attenuated by the injection of 10 c.c. of gamma globulin during the incubation period, but that it has no effect on the course of the disease after its actual onset. It has been found to have little value in the attenuation of mumps orchitis[48] or preparalytic poliomyelitis.[49]

C. *Rocky Mountain Spotted Fever Vaccine.* Since there is an unusual geographic concentration of infected ticks in the Washington area and its outlying suburbs, the use of tick vaccine assumes particular importance. The Cox vaccine is made from the infected yolk sac of the developing chick embryo, and the rickettsia is inactivated by formalin. It is advisable to give the vaccine in the late winter or early spring, and the immunization must be repeated each year. In those instances in which an allergy to egg exists the Cox vaccine is contraindicated, since it is grown on egg media; in such cases it is advisable to give vaccine prepared from macerated infected ticks. Neither vaccine is of value in the treatment or in prevention following the bite of an infected tick.

The recommended dosage is as follows:

1. Children less than 5 years: 2 subcutaneous injections of 0.5 c.c. each 10 days apart.
2. Children 5–10 years: 3 subcutaneous injections of 0.5 c.c. each at intervals of 7 to 10 days.
3. Children over 10 years and adults: 3 subcutaneous injections of 1 c.c. each at intervals of 7 to 10 days.

D. *Mumps Vaccine.* Enders[50] has recently reported on a vaccine against mumps prepared by the formol-inactivation of a suspension of infected parotid gland from monkeys. Stokes and Maris gave this vaccine to a group of 16 children who were experimentally inoculated with the active monkey virus; the controls who did not receive vaccine were also inoculated with active virus. Preliminary reports on the result of this experiment showed that three fourths of the vaccinated children presented evidence of increased resistance as contrasted with about one fourth of those in the control group.

Both Enders[51] and Habel[52] have succeeded in growing mumps virus in the developing chick embryo, which is in effect a convenient and inexpensive method for producing large quantities of mumps vaccine. No experiments on human beings with the formol-inactivated mumps vaccine obtained from the egg embryo have as yet been attempted.

Enders[53] has also perfected a mumps skin test by means of which it is possible to distinguish the susceptible from non-susceptible individuals within an error of 10 per cent or less.

E. *Influenza Vaccine.* Recently a bivalent anti-influenza A and B vaccine has been prepared under the aegis of the Commission on Influenza by the concentration of the influenza virus in chorio-allantoic fluid and inactivation by formalin. In a controlled study of 12,000 A.S.T.P. students, it was concluded[54] that immunization with the vaccine afforded approximately 75 per cent protection for a few months against the 2 most prevalent strains of influenza.

The routine use of the vaccine in the pediatric age group has no real justification except in the presence of an epidemic of influenza A or B. A contraindication to its indiscriminate use is the possibility that sensitivity to the egg protein in the vaccine will induce severe reactions, especially in view of the necessity of giving repeated booster doses of the vaccine to maintain a measure of immunity.

The usual untoward reactions from the vaccine include fever, inflammation at the site of injection, and simulated attacks of influenza.

Grant[55] has reported that 1 c.c. doses in children produce more severe and more frequent febrile reactions than in adults and recommends 0.5 c.c. as an optimal dose for the pediatric age group.

Sulfonamides, Penicillin and Streptomycin in Pediatrics

The use of the sulfonamide drugs and the antibiotics, penicillin and streptomycin, deserves a high priority consideration in any discussion of the recent advances in pediatrics. With the advent of the antibiotics during the past 2 to 3 years the tendency has been to emphasize their importance and inferentially to minimize the role of sulfonamides in current-day pediatrics. Testimony to this trend is afforded by the plethora of reports in the recent literature regarding the efficacy of the antibiotics and the paucity of recent papers on the sulfonamide drugs. However, it is well to point out that sulfonamides, especially sulfadiazine, still occupy a very important position in the management of infections in children. This is especially true in the cases of upper respiratory infections which constitute a considerable percentage of those seen in everyday practice and which can be managed at home adequately on sulfonamides.

The question of preference of either sulfadiazine or penicillin in those infections where their efficacy overlaps (i.e., gram positive and negative cocci) must be decided on the individual merits of the case. The severity and the type of infection would be important desiderata. Penicillin is considerably more effective than sulfadiazine in certain coccal infections including those due to staphylococcus, non-hemolytic streptococcus, Streptococcus viridans and gonococcus. Sulfadiazine, on the other hand, is the drug of choice in meningococcal infections. In those coccal infections in which sulfadiazine and penicillin are both extremely effective, viz., those due to the pneumococcus and B. hemolytic streptococcus, some of the other factors warrant consideration. The necessity of giving frequent injections of penicillin (often a traumatic experience psychologically for the child), the higher cost of this drug, together with the fact that hospitalization is usually mandatory when penicillin is employed, must be weighed against the shortcomings of the sulfonamides; these include the greater toxic effects of sulfadiazine, the higher incidence of acquired sulfonamide resistance of bacteria, the occasional allergic sensitization of the patient, and the cost of laboratory work associated with sulfonamide drug administration (i.e., blood counts, urinalysis and sulfonamide blood levels).

With regard to streptomycin in pediatrics, perhaps its chief value (in so far as frequency is concerned) would be its use in urinary tract infections due to gram negative bacilli, hemophilus pertussis, H. influenza, and dysentery.

The following tables attempt to present a concise survey of the infections commonly encountered in infants and children together with a commentary on the drug of choice, the recommended dose and the duration of treatment. It is well to emphasize, however, that the data on dosage and duration of therapy are perforce only first approximations based on our experiences and those of others reported in the literature; in the last analysis, the amount of therapy will have to be largely predicated on the severity of the illness and the response of the individual child.

TABLE 1

Mode of Administration of Chemotherapeutic and Antibiotic Drugs

ROUTE	SULFADIAZINE	PENICILLIN	STREPTOMYCIN
Oral	Readily absorbed from GI tract. Not inactivated by HCl in stomach. Tablets—gr. 7.7. "Cocodiazine"—1 tsp. = 5 gr. "Eskadiazine"—1 tsp. = 7.8 gr. Preferable mode of administration whenever possible. In mild infections one gr./lb./24 hours; maintain sulfa level 4–6 mg. %.	Partially inactivated by HCl in stomach. When oral administration used, 3–5 times parenteral dose required. Buffer probably not necessary. Tablets preferably taken on empty stomach and swallowed whole. Tablets = 25,000 units. Adequate mode of administration in less severe types of penicillin susceptible infections; dosage 50,000–75,000 units every 3 hours.	Not inactivated by HCl of stomach. Useless in systemic infections since so little absorbed from GI tract. Indicated for preoperative bowel surgery to reduce number of bacteria or GI infections .
Subcutaneous	Method of choice in severe infections. Sodium salt given in 1% to 5% solution. Diluent may be n. saline, 1/6 molar lactate, 5% glucose in Hartmann's, or sterile water. Dose ranges from 1 to 3 gr./lb./24 hr. depending on severity of infection. Divide into 3 or 4 doses a day (every 6 or 8 hrs.). Maintain level between 8–15 mg. %. Preliminary hydration advisable. Do not use sulfa drug in same drip with blood, plasma or amino acids.	Infrequently used because of local pain and irritation at site of injection.	May be used but produces pain and irritation at site of injection.
Intramuscular	Not indicated	Intermittent intramuscular every 2 or 3 hours is the preferable mode of administration in majority of cases. Penicillin diluted up with n. saline or distilled water so that 1 c.c. = 5,000–20,000 units. Arbitrary dosage schedule of 10,000 units every 3 hours in mild infections; 15,000–20,000 units every 2 or 3 hours in severe infections. Continuous IM impractical in pediatric age group because of undue discomfort. Penicillin in 4% beeswax and peanut oil maintains blood levels for 6–10 hours.	Intermittent intramuscular is preferable mode of administration. Doses repeated every 3–4 hrs. Streptomycin diluted up with distilled water so that 1 c.c. = 50,000 units. Optimal dosage for infants and children still indeterminate. Suggested range of 50,000–200,000 units every 3 hours depending on severity and type of infection.

TABLE 1—*Concluded*

ROUTE	SULFADIAZINE	PENICILLIN	STREPTOMYCIN
Intravenous	Less preferable in pediatric age group because of greater risk of renal complications. If employed, use sodium sulfadiazine (1 to 5%) and preliminary hydration and concurrent alkalinization. Watch carefully for hematuria, oliguria and anuria.	Intermittent IV impractical in children and has no particular advantage over intermittent IM. Continuous IV occasionally indicated in very severe infections. Impractical for routine use.	No advantage over IM route.
Inhalation	Not indicated	May be used in pulmonary infections susceptible to penicillin. Nebulized solution concentration 1 c.c. = 20,000–100,000 units penicillin.	Useful in mixed bronchopulmonary infections susceptible to streptomycin (concentration 50,000 units/c.c.)
Intrathecal	Contraindicated	Indicated in meningitis due to Staph., Strep., or Pneumococcus. 1 c.c. = 1,000 units. Do not give more than 5,000–10,000 units per dose. Repeat 1–2 times daily and use concurrently with IM administration.	Indicated in meningitis due to Coliform group and H. influenza. Also has suppressive effect in Tbc meningitis. 25,000–50,000 units per day (1 c.c. = 5,000 to 10,000 units) to be given concurrently with IM administration.
Intrapleural	Contraindicated	Indicated in penicillin susceptible empyema. Instill 25,000 units daily. Use concurrently with IM penicillin.	Desirable when high concentration necessary in pleural cavity in empyema. Instill 50,000–100,000 units daily in pleural space. Use concurrently with IM streptomycin.
Intra-articular	Contraindicated	Indicated in pyogenic arthritides (Strep., Staph., and Pneumococcus). Instill 25,000 units on alternate days.	Not reported.
Topical	5% sulfathiazole ointment. Use water-soluble rather than petrolatum base.	May be used as solution (1 c.c. = 250–500 units) or as ointment with water-soluble base.	Not reported.

TABLE 2

Indications for Various Types of Chemotherapeutic and Antibiotic Agents

TYPE OF INFECTION	DRUG OF CHOICE	COMMENT
I. Staphylococcal		
1. Acute osteomyelitis	Penicillin and sulfadiazine combined	Approximately 300,000 units per day of penicillin for 3–5 weeks. Sulfadiazine 2 gr./lb./24 hrs. Surgery necessary only in presence of large soft tissue abscesses. Danger of relapse if penicillin discontinued too soon. Recoveries approach 85%.
2. Chronic osteomyelitis	Penicillin	Results not too satisfactory. Sequestrectomy necessary. Maintain therapy for 3–6 weeks. Additional local administration of penicillin (500 u/c.c.) postoperatively.
3. Carbuncles, cellulitis and soft tissue abscesses.	Penicillin	Administer approximately 150,000 units/day for 7–10 days. Surgical drainage of pus if necessary.
4. Meningitis	Penicillin and sulfadiazine combined	Approximately 250,000 units/day of penicillin intramuscularly and 10,000 units intrathecally daily. Continue IM for 7–10 days after temperature normal and intrathecally for 4–6 days after spinal fluid sterile. Sulfadiazine gr. 2–3/lb./24 hrs.; continue until temperature normal for 10 days. Maintain sulfa level 10–15 mg. %.
5. Pneumonia and empyema	Penicillin and sulfadiazine combined	Approximately 250,000 units of penicillin/day and sulfadiazine gr. 2–3/lb./24 hours; maintain therapy for 7–10 days after temperature normal. When empyema present, instill 25,000 units of penicillin daily into pleural space (1 c.c. = 1000 u). If no improvement, thoracotomy necessary.
6. Cutaneous infections including impetigo and pyodermia.	Penicillin	Approximately 100,000 units of penicillin/day. Usually clears rapidly. Topical penicillin or 5% sulfathiazole ointment efficacious in milder cases.
II. Streptococcal		
1. Upper respiratory infections including pharyngotonsillitis, otitis media and mastoiditis.	Penicillin or sulfadiazine	Streptococcus quite susceptible to either penicillin (100,000 units/day) or sulfadiazine (gr. 1–2/lb./24 hours). Maintain therapy for 3–5 days after temperature normal.
2. Acute laryngotracheobronchitis	Penicillin and sulfadiazine combined	Child usually critically ill. Penicillin 150,000 units per day and sulfadiazine gr. 2–3/lb./24 hours.
3. Scarlet fever	Penicillin	Administer 150,000 u/day for 5–7 days. Reduces incidence of complications and produces negative throat cultures rapidly (usually within 7 days).
4. Primary peritonitis	Penicillin and sulfadiazine combined	Mortality about 30% with sulfa drug alone. With combined therapy, mortality probably 10–20%. Penicillin 200,000 u/day; sulfadiazine gr. 2–3/lb./24 hours.

TABLE 2—*Continued*

TYPE OF INFECTION	DRUG OF CHOICE	COMMENT
5. Subacute bacterial endocarditis	Penicillin	Sensitivity of organism should be ascertained before therapy initiated. Approximately 300,000 units of penicillin a day for about 1 month. Higher dose necessary if relapses occur. Heparin not necessary. Four to 6 months' follow-up indicated. May expect 75% recoveries with above régime.
III. Pneumococcal		
1. Meningitis	Penicillin and sulfadiazine combined	Penicillin—approximately 250,000 units IM and 10,000 units intrathecally per day (1 c.c. = 1000 units). Continued IM penicillin for 7–10 days after temperature normal and intrathecal penicillin for 4–6 days after spinal fluid sterile. Sulfadiazine gr. 2–3/lb./24 hrs.; continue sulfa drug until temperature normal for 10 days. Type specific antiserum not usually necessary. May expect 85% recovery if infection treated early and energetically.
2. Pneumonia	Penicillin or sulfadiazine	Approximately 100,000–150,000 units IM/day for 4–5 days is adequate in most cases. Oral penicillin (50,000–75,000 units every 3 hrs.) for a total of 1½–2 million units yields satisfactory results also. Empyema should receive additional intrapleural penicillin (25,000 u/day) for 3–4 days; thoracotomy not usually necessary. Sulfadiazine also very effective in Pneumococcus pneumonia. Can expect 90–95% recoveries with either drug. Use combined sulfa and penicillin in severely ill patients.
IV. Gonococcal		
1. Ophthalmia of the newborn	Penicillin	Penicillin 10,000 units every 3 hours IM for 10–12 doses is usually adequate. Penicillin solution or ointment topically not necessary.
2. Vulvovaginitis or urethritis	Penicillin	Penicillin 20,000 units every 3 hours for 8 doses curative in 95% cases. Oral penicillin effective in dosage of 50,000 units every 3 hours for 8 doses. Criteria of cure are 3 negative cultures over 21-day follow-up. If Herxheimer elicited during therapy, suspect coexistent syphilis. Two doses of 100,000 units of penicillin in peanut-oil and beeswax at 12-hour intervals also effective treatment.
V. Meningococcal		
1. Meningitis	Sulfadiazine	Excellent results with sulfadiazine alone with 95% recoveries. Give 2–3 gr./lb./24 hours and continue for 7–10 days after temperature normal. Penicillin as supplementary therapy may be used in presence of associated meningococcemia or in cases not responding to sulfadiazine alone. Meningococcal antiserum not necessary.
VI. Congenital syphilis	Penicillin	Total dose = 50,000 units/lb. body weight in 3-hour divided doses for 10 days. Serological reversal usually within 3–6 months with improvement in osseous lesions within 1–3 months. May expect 75% recoveries with this régime. Herxheimer's occur in 50% of cases but are not injurious. Advisability of concurrent bismuth and/or mapharsen still indeterminate.

TABLE 2—*Continued*

TYPE OF INFECTION	DRUG OF CHOICE	COMMENT
VII. Vincent's angina	Penicillin	Both intramuscular and topical application of penicillin indicated. IM dose 10,000 units every 3 hours for 2 days. Penicillin administered topically by spray, gargle, lozenges, pastilles or swab every 3 hours good adjuvant therapy.
VIII. Clostrideal infections (tetanus and gas gangrene)	Antitoxin; penicillin	Penicillin to be used both locally and IM but has no antitoxic action and is to be looked upon as adjunctive therapy only. Antitoxin and surgery are still mainstays of therapy.
IX. Hemophilus influenza		
1. Meningitis	Combined sulfadiazine, streptomycin and H. influenza antiserum	Combined therapy will yield approximately 86% recoveries. Early therapy of prime importance. Streptomycin 50,000–75,000 units every 3 hours IM for 8–10 days and 50,000 units intrathecally daily for 1 week. Sulfadiazine gr. 2–3/lb./24 hours; maintain sulfa level 10–15 mg. %; continue sulfa therapy for 7–10 days after temperature normal. H. influenza rabbit antiserum may be omitted in mild cases. When used, give an average of 8–10 ampules IM or IV.
2. Acute laryngotracheobronchitis (including epiglottitis)	Sulfadiazine, streptomycin and H. influenza antiserum	In laryngo-tracheobronchitis, combined sulfadiazine, streptomycin and rabbit antiserum recommended in same dosage as above. Tracheotomy indicated when epiglottitis present.
X. Pertussis	Streptomycin and hyperimmune antiserum	No cases of pertussis treated with streptomycin have been reported in literature to date. Organism susceptible to streptomycin in vitro. Hyperimmune serum (1 to 3 ampules) should be used until streptomycin evaluated. Cutter's hyperimmune serum = 2.5 c.c. per ampule. Philadelphia serum (hyperimmune) = 20 c.c. per ampule; 2–3 ampules recommended.
XI. Urinary tract infections due to gram neg. bacilli including E. coli, Pseudomonas, Proteus, Aerobacter aerogenes and others	Streptomycin	Dose 50,000–100,000 units every 3 hours IM for 6–8 days yields recovery in approximately 50% of cases. Unrelieved urostasis due to obstructive lesions and rapid development of resistance of organisms accounts for failure in other 50%.
XII. Tularemia	Streptomycin	Dose 75,000–100,000 units every 3 hours IM for 7 days. Improvement dramatic with 95% recoveries reported.
XIII. Peritonitis following ruptured appendix	Combined streptomycin and sulfadiazine	Difficult to evaluate role of any type of chemotherapy because of many variables. Advisable to use sulfadiazine in addition to streptomycin because of presence of gram positive cocci in addition to Coliform group. Both drugs diffuse into peritoneal cavity. Can expect recoveries with combined therapy in 90%. Efficacy of penicillin is still indeterminate.
XIV. Tuberculosis		
1. Pulmonary Tbc	Streptomycin	Streptomycin is palliative but does not eradicate infection. Suggested dosage—100,000–200,000 units every 3 hours IM for 3–6 months. In Tbc meningitis, simultaneous intrathecal installation of 50,000 units/day for 2–3 months.

TABLE 2—*Concluded*

TYPE OF INFECTION	DRUG OF CHOICE	COMMENT
2. Tbc meningitis	Streptomycin	See above.
XV. Typhoid fever	Streptomycin	Dose 200,000–400,000 units every 3 hours IM for 7 days. Results disappointing; no evidence that streptomycin shortens course of disease even with combined parenteral and oral administration. May possibly have value in early cases.
XVI. Brucellosis	Streptomycin	Dose 200,000–400,000 units every 3 hours IM for 2–3 weeks. Results disappointing; non-dramatic improvement may be expected in some cases.
XVII. Dysentery (Shigella)	Streptomycin and/or sulfadiazine	Dose 50,000–100,000 units every 3 hours IM for 7 days. Can expect moderately good results with sulfadiazine alone.
XVIII. Salmonella infections	Streptomycin	Dose 300,000–400,000 units every 3 hours IM for 2–3 weeks. Results not too encouraging. Variation in sensitivity of individual strains. Can expect about 40% recovery.

BIBLIOGRAPHY

1. Gregg, N. N.: Proc. Roy. Ophth. Soc., Australia, 1941. **3**, 35.
2. Swan, C., and others: M. J. Australia, 1943, **2**, 201.
3. Reese, A. B.: Am. J. Ophth., 1944, **27**, 483.
4. Rones, B.: M. Ann. District of Columbia, 1944, **13**, 285.
5. Erickson, C. A.: J. Pediat., 1944, **25**, 281.
6. Conte, W. R., McGammon, C. S., and Christie, A.: Am. J. Dis. Child., 1945, **70**, 301.
7. Fox, M. J., and Bortin, M. M.: J. A. M. A., 1946, **130**, 568.
8. Blalock, A., and Taussig, H. B.: Ibid., 1945, **128**, 189.
9. Taussig, H. B.: Personal communication.
10. Gross, R. E., and Hubbard, J. P.: J. A. M. A., 1939, **112**, 729.
11. Touroff, A. S. W.: Am. Heart J., 1943, **25**, 187.
12. Gross, R. E.: Surg., Gynec., & Obst., 1944, **78**, 36.
13. Davis, E.: Personal communication.
14. Gross, R. E.: Surgery, 1946, **20**, 1.
15. Faber, H. K., Hope, J. W., and Robinson, F. L.: J. Pediat., 1945, **26**, 128.
16. Gross, R. E., and Hufnagel, C. A.: New England J. Med., 1945, **233**, 287.
17. Coburn, A. F., and Moore, L. V.: J. Clin. Investigation, 1939, **18**, 147.
18. Thomas, C. B., and France, R.: Bull. Johns Hopkins Hosp., 1939, **64**, 67.
19. Coburn, A. F., and Moore, L. V.: M. Clin. North America, 1940, **24**, 633.
20. Kuttner, A. G., and Reyersbach, G.: J. Clin. Investigation, 1943, **22**, 77.
21. Thomas, C. B., France, R., and Reichsman, F.: J. A. M. A., 1941, **116**, 551.
22. Fullerton, C. W.: Canad. M. A. J., 1945, **52**, 559.
23. McLeod, J. H., Emmons, C. W., Ross, S., and Burke, F. G.: J. Pediat., 1946, **28**, 275.
24. Darling, S. T.: J. A. M. A., 1906, **46**, 1283.
25. Parsons, R. J., and Zarafonetis, C. J. D.: Arch. Int. Med., 1945, **75**, 1.
26. Palmer, C. E.: Pub. Health Rep., 1945, **60**, 513.
27. Emmons, C. W., Olson, B. J., and Eldridge, W. W.: Ibid., 1945, **60**, 1383.
28. Christie, A., and Peterson, J. C.: J. Pediat., 1946, **29**, 417.
29. Mollison, P. L.: Arch. Dis. Childhood, 1943, **18**, 161.
30. Davidsohn, I.: Am. J. Clin. Path., 1945, **15**, 95.
31. Diamond, L. K.: New England J. Med., 1945, **232**, 475.
32. Levine, P., and Waller, R. K.: J. Hematology, 1946, **1**, 143.
33. Spies, T. D., Vilter, C. F., Koch, M. B., and Caldwell, M. H.: South. M. J., 1945, **38**, 707.
34. Zuelzer, W. W., and Ogden, F. N.: Am. J. Dis. Child. 1946, **71**, 211.
35. Zuelzer, W. W.: J. A. M. A., 1946, **131**, 7.
36. Moore, C.: J. Lab. & Clin. Med., 1945, **40**, 1056.
37. Minot, G. R., and others: J. Clin. Investigation,1945, **24**, 704.
38. Cohen, P., and Scadron, S. J.: J. A. M. A., 1943, **121**, 656.
39. Kendrick, P., Thompson, M., and Eldering, G.: Am. J. Dis. Child., 1945, **70**, 25.
40. Sauer, L. W.: Am. J. Path., 1941, **17**, 719.
41. Sako, W., Treuting, W. L., Witt, D. B., and Nichamin, S. J.: J. A. M. A., 1945, **127**, 379.
42. Waddell, W. W., Jr., and L'Engle, C. S., Jr.: J. Pediat., 1946, **29**, 487.
43. Lapin, J. H.: Ibid., 1946, **29**, 90.
44. Strean, L. P.: Canad. M. A. J., 1940, **42**, 525.
45. Sweet, L. K., and Hickman, J. L.: J. Pediat., 1946, **28**, 566.
46. Janeway, C. A.: J. A. M. A., 1944, **126**, 674.
47. Stokes, J., Jr., and Neefe, J. R.: Ibid., 1945, **127**, 144.

(*Continued on page 118*)

THE FUTURE OF VENEREAL DISEASE CONTROL*

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I AM extremely glad to have this opportunity to speak before the Medical Society of the District of Columbia on a subject which is of very great mutual concern to all of us, the future of venereal disease control

It is gratifying that this local Medical Society has seen fit to devote time to considering this subject. It is extremely important that individual communities display sincerity and diligence in efforts to control venereal disease in individual communities, since the national problem can be solved only through the solving of many local problems. It is also extremely important to both individual communities and to the Nation as a whole that physicians in private practice take leadership in controlling syphilis and gonorrhea. Today, more than ever before, the practicing physician is a key man in venereal disease control.

Because the District of Columbia is the Nation's capital, health problems here, probably like many other municipal problems, tend to be in the spotlight of public attention perhaps just a little more than in most other cities of comparable size.

Nevertheless, the basic problems of venereal disease control in the District of Columbia are essentially the same as they are in most other cities. Naturally, I am better informed on the problems which cities throughout the Nation have in common than I am on the special aspects of those problems as they exist in the District. Therefore, I will devote my time this morning to presenting to you a broad outline of the national venereal disease control problem as I have seen it from the perspective of the Venereal Disease Division of the Public Health Service.

I believe that the prospects for ultimate effective control of the venereal diseases in the United States are brighter today than at any previous time in the history of medicine and public health. This optimistic outlook for the future is based in part on what has already been accomplished in recent years.

I should like to summarize, briefly, some of the progress that has been achieved within the past few years as a result of planning, effort and persistence.

The number of deaths due to all forms of syphilis has declined steadily from 15 deaths per 100,000 population in 1939 to a new low estimated at about 10.7 deaths per 100,000 for 1945. The percentage of infant deaths due to syphilis has been reduced by more than one half, from 57 deaths per 100,000 live births in 1939, to 27 per 100,000 in 1944.

As reflected both in admissions to institutions and in recorded deaths, there has been a steady decline in the incidence of late forms of neurosyphilis In 1920, the national paresis death rate was 6.32 per 100,000 population; by 1944, this had been reduced by nearly half, to 3.49 per 100,000. The tabes dorsalis death rate per 100,000, which was 2.06 in 1920, had dropped dramatically to 0.40 per 100,000 in 1944.

These declining morbidity and mortality rates are evidence of real progress. They are particularly encouraging when it is realized that they were achieved despite the prolonged disruptive influence of a great war. Credit for the fact that increases in the incidence of syphilis were prevented during the War, and that actual decreases in the attack rate were achieved in some areas, is shared by the armed forces, state and local health departments, the civilian medical profession, the Public Health Service, and many other coöperating groups throughout the country.

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* Read at the Seventeenth Annual Scientific Assembly of the Society, October 1, 1946.

The striking progress that has been made during the past 10 years does not mean, however, that the venereal diseases can be regarded as already under control, nor that their control in the future will be simple and easy. On the contrary, the estimated current yearly incidence of 250,000 new cases of syphilis, and a million or more cases of gonorrhea, means that there is a long and difficult road ahead. However, in contrast to the outlook which prevailed only a few years before the War, when no clear road to ultimate control of syphilis and gonorrhea was discernible, we can say today that the map is being drawn. It is being charted by biochemists, organic chemists, physicians in their private offices, in hospitals and in clinics; it is being drawn by health departments and their administrators, educators, interviewers, and contact investigators.

Now, after several years of progress, we have come to a point where the number of cases of venereal disease reported by state health officers, which includes those discovered by the armed forces, has risen sharply. The rise in the second half of the fiscal year 1946 has been at the rate of approximately 42,000 more cases of early syphilis per year and about 70,000 more cases of gonorrhea reported.

This increase, however, is correlated with the return of personnel from the armed forces and does not necessarily reflect an increase in the rate of attack of the venereal diseases.

The rise has accompanied the return to the civilian population of 11 million young men formerly in the armed forces, and the attack rate among these 11 million, because of their age range, obviously is high compared with that of the total population, or the wartime civilian population.

However, the fact that we have 11 million men of the age range in which the attack rate of the venereal diseases is relatively high is accompanied by the encouraging fact that we have also back in the civilian population and in civilian practice thousands of physicians who are fully aware of the importance of venereal disease control and who are skilled in effective methods of achieving that control.

In contemplating the road ahead, we might well review the three basic methods by which the venereal diseases can be controlled. The first of these is finding and treating infected persons, thereby eliminating the sources of new infections. The second is by reducing the number of noninfected persons who become exposed; this might be done, on the one hand, by persuading noninfected persons not to expose themselves, or, on the other hand, by influencing infected persons not to infect others. The third basic means of venereal disease control is that of reducing the number of new infections which result from whatever exposures actually occur.

I shall reserve for the last, discussion of the first method—finding and treating infected persons—and shall speak only briefly of the other two.

The problem of reducing the number of noninfected persons who expose themselves to venereal disease is the problem of what, for want of a more appropriate name, has been called "promiscuity." It is a long-range problem in the fields of sociology, psychology, education, and other intangible fields which are fields mostly outside the professional skills and jurisdiction of health officers. It is true that some sexual behavior leading to venereal disease infections is the result of emotional immaturity or maladjustment, and that mental hygiene and psychiatry may provide a useful medical approach to this problem; however, progress in this field is embryonic in so far as venereal disease control is concerned today, and a great deal of research will be necessary before any technics applicable on a scale wide enough to influence the venereal disease rate may be expected. When the problems of venereal disease control are viewed before the background of the history of civilization, it seems obvious that halving or even quartering the extent of so-called sexual promiscuity will not, by itself, control venereal disease. In other words, the often repeated statement that "venereal disease is more than just a medical problem" can be stated conversely: "Venereal disease is more than just a morality problem"—for we still have with us the spirochete and the gonococcus.

Nevertheless, venereal disease control will benefit in a lower rate of infection to whatever extent the educational system, churches, welfare agencies, and other groups concerned with the environmental and biologic influences which determine the sexual conduct of the masses succeed in reducing promiscuous sexual behavior.

As for reducing the number of new infections resulting from actual exposures that actually occur, that is in reality a statement of the objectives of prophylaxis which has proved to be of great value in the armed services where the habits and actions of large numbers of people can be influenced directly. There are many, however, who believe that the use of prophylaxis among the general population on a scale likely to reduce the incidence of syphilis and gonorrhea to a status anything like what could be called control would be extremely difficult and, for all practical purposes, impossible.

The fact that efforts to reduce promiscuity and to increase the use of prophylaxis among the persistently promiscuous cannot be expected to eliminate all venereal disease entirely does not mean, of course, that these two objectives should be abandoned, for every single case of venereal disease prevented by any method is one small step toward final control. However, it does seem that some more direct attack on the problem is indicated.

Let us now return to more careful consideration of the basic method of controlling venereal disease by finding and treating infected persons. This is the means with which the health department is immediately concerned, the means which the health department most readily and appropriately can apply, and the means which offers the most immediate prospect of controlling venereal disease.

As everyone here today is aware, the medical problem of rendering both gonorrhea and syphilis patients noninfectious by treatment has been solved more nearly completely than have any of the other venereal disease problems.

Physicians in private practice and clinics now have effective methods of treating gonorrhea with penicillin, either in aqueous solutions, or in oil and beeswax mixtures. Indeed, treatment of the vast majority of gonorrhea patients can be completed in just a few minutes, or, at most, in a few hours. Out of every hundred cases of gonorrhea treated with penicillin, there may be a few requiring additional courses of therapy but, to my knowledge, there have as yet appeared none that could be regarded as truly resistant to penicillin.

Although we are today a long way from final evaluation of the various intensive schedules for treating syphilis, we know that the great majority of infectious cases can be rendered noninfectious by therapy employing penicillin, arsenic, and bismuth in various combinations administered in hospitals over a period of two weeks or less. We know, further, that intensive inpatient treatment of infectious syphilis by these new methods has greatly reduced the case-holding problem which for so many years retarded real progress in the control of syphilis.

During recent weeks there have been several articles appearing in the newspapers regarding the chemistry of penicillin. For the first time, the public has learned that there are at least four fractions which may occur in varying proportions in different lots of commercial penicillin. It has been found from laboratory research and clinical experience that the fraction designated as penicillin K is far less effective in the treatment of both syphilis and gonorrhea than are other fractions, particularly penicillin G, when employed in currently used schedules of therapy. Furthermore, there is reason to believe that some of the impurities which appeared in the earlier, cruder penicillin, may have been of therapeutic value in the treatment of syphilis, and that these so-called impurities may not be present in significant quantities in today's more highly refined commercial penicillin products.

These recent discoveries regarding the chemistry of penicillin, however, by no means should be looked upon as omens that penicillin will prove to be any less efficacious in the treatment of syphilis than originally was hoped when Mahoney first announced results of his preliminary studies. On the contrary, they indicate that the day is not too far distant when, knowing the structural formula of those fractions of penicillin which are specific for syphilis and gonorrhea, the chemists will be able to synthesize and produce those fractions on a large scale, thus making them widely available and further reducing the variables in the treatment of the two diseases.

There are, of course, many problems in the intensive treatment of syphilis which remain to be solved to the full satisfaction of clinicians. One of these is the perfection of a method for rapid treatment of syphilis on an ambulatory, rather than an inpatient basis. The history of medicine tells us that we should look with confidence to the comparatively near future when most of these problems will be solved.

But even when we may have a virtually 100 per cent effective means for treating syphilis, as well as gonorrhea, we shall be a long way from venereal disease control until we have solved the problem of promptly finding the individuals who have the disease in the infectious stage so that they may be treated. It is estimated that today approximately one fourth of all early cases of syphilis, and a much larger proportion of all gonorrhea infections, elude discovery during the communicable stages. The problem of discovering these elusive cases and bringing them to treatment promptly, if it can be solved, is the real key to the future of venereal disease control.

Several methods have been employed in finding these all-important infectious cases. The theoretically ideal method is by contact investigation, determining from interviews with newly discovered patients the names and addresses of all individuals to whom or from whom their infections may have spread, quickly locating those individuals, examining them, and treating them if they are found to be infected. It is obvious that, in theory, each newly discovered infection should lead to at least one other infection. In practice, however, the average number of infected persons brought to treatment per patient interview is something less than one. If contact investigation could be made 100 per cent efficient, venereal disease would be brought under control promptly. It is clear that one of the immediate problems of venereal disease control is to increase the productivity and speed of contact interviewing and investigation.

Mass blood testing is another method of case-finding of value in the control of syphilis, particularly in areas where the prevalence and incidence are high. One flaw in the method is that blood testing does not reveal syphilis in the very early stage. Furthermore, it does not directly detect gonorrhea, although the discovery of gonorrhea is often a valuable by-product of mass blood testing. Still another mass case-finding method, similar to mass blood testing, is that in which blood testing and physical examinations for the lesions of syphilis, and for gonorrhea, and interviews, are combined with tests for other diseases such as tuberculosis, or combined with complete general physical examinations. Outstanding examples of this method applied on an enormous scale are the examinations conducted in connection with the Selective Service program and the current demobilization program. These mass examinations have yielded many thousands of cases of infectious venereal disease which otherwise would have escaped early detection.

But the vast wartime Selective Service program is well in the past, and the separation center program has passed its peak. With respect to the future of venereal disease control, these two important programs are now chiefly of historic interest.

Routine blood tests, such as the premarital and prenatal blood testing required in most states, are also useful case-finding devices, as are the routine physical examinations which include incidental blood testing of which industrial health examinations are an example.

Today the most productive single case-finding source is the blood testing and physical examination of persons who voluntarily consult physicians or clinics because they believe they may have been exposed to venereal disease. Continuous education of the public is the key to results from voluntarily sought examinations, and one of the urgent tasks in the future of venereal disease control is the intensification and broadening of public education work which brings infected persons to treatment promptly.

Within the past year and a half a new mass case-finding technic has developed, the community-wide blood testing or physical examination of individuals within the age ranges in which syphilis and gonorrhea are prevalent. Several such community-wide programs have been conducted, so far primarily as demonstrations. At the request of state and local health departments, the Venereal Disease Division of the U. S. Public Health Service has coöperated with local health officers in a number of these demonstrations. In none of the demonstrations have the objectives, methods, circumstances, or results been identical. The interest of the Public Health Service in the demonstrations is twofold: first, to further the control of venereal disease by providing technical consultation service and financial aid to health officers who call upon the Division, and second, to study and compare the large number of variables in the several demonstrations. When studies have been completed, the Venereal Disease Division of the U. S. Public Health Service hopes to be able to report which factors are important in case-finding in different types of communities, so that recommendations can be made as to the application of the most appropriate methods in various other areas throughout the country.

Today it seems very likely that some variation of community-wide case-finding programs of this general character may prove to be the means to ultimate control of syphilis and gonorrhea. It is apparent that if a great majority of the infectious cases of syphilis and gonorrhea in a great majority of the communities of the Nation can be discovered and brought to treatment by mass case-finding, the incidence of the venereal diseases would be reduced to a small fraction of what it is now.

We must recognize, however, that even if community-wide case-finding programs were conducted in every hamlet and city in the Nation, a few cases would escape detection by existing means of diagnosis, and these few undetected cases would provide the seed from which an almost limitless number of new cases might ultimately grow again unless constant vigilance were maintained.

Some venereal disease control workers are looking ahead, speculatively at least, to a future of unknown distance when some mass technic more nearly perfectly efficient than anything yet discovered may evolve. One prospect which has been speculated upon is the mass administration of penicillin, or perhaps other as yet undiscovered antibiotics, to entire populations to eliminate even the small residue of venereal disease infections, and possibly other infections, which escape existing case-finding methods.

Syphilis has always been a challenge to physicians in the past. It remains so today. But in the future that challenge will more and more become one to test the ingenuity of the practicing physician, the health officer, and all others concerned with venereal disease control to find and bring to treatment the last infectious case.

THE PSYCHOSOMATIC APPROACH TO PEPTIC ULCER*

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I SPEAK as a practitioner of medicine and not as a psychiatrist, and that is a very different matter. When a patient comes to the psychiatrist he comes prepared to discuss his emotional problems, but when he consults a general physician he is almost always looking for a physical cause for his trouble.

But in at least one third of all the patients who consult a physician no definite bodily disease can be found to account for the illness, and in another one third of all patients the symptoms are not explained by, or are out of proportion to, any organic disease that can be discovered. In a third group of patients there seems to be a definite relationship between the emotional life and the physical disease; in other words, the emotional factor plays an important part in causing the physical disorder. This is the group to which the term psychosomatic affection is often applied, and it is in this group that peptic ulcer belongs.

While psychosomatic is a new term, it describes an approach to medicine as old as the art of healing itself. It is not a new specialty but rather a point of view which applies to all aspects of medicine and surgery.[1] It connotes the simultaneous application of physiologic and psychologic technics in the study of illness. It does not mean to study the soma less; it only means to study the psyche more. Its subject matter is founded on the important advances in physical medicine as well as on the biologically oriented psychology of Freud without whose epochal discoveries no work on psychosomatic medicine could be attempted. It is not a new discovery, but rather a reaffirmation of the ancient principle that the mind and the body are interactive and interdependent, a principle that has always guided the intelligent general practitioner. Indeed the traditional old family doctor very often was an excellent psychosomatic physician, although he never thought of himself as such. His patients usually were intimate friends, and he was familiar with their social situation, as well as with their psychologic and physical peculiarities. He was well aware that these factors were related to illness. As a science, psychosomatic medicine aims at discovering the precise nature of the relationship for the greater benefit of doctors and patients alike. It can be said that psychiatry was established on a firm scientific basis in World War I, and World War II has seen its more complete integration into general medicine. When that integration is accomplished there will be little need for the term psychosomatic; good medicine will be psychosomatic medicine.

How can we relate this material to the gastrointestinal tract? The abdomen has often been called the sounding board of the emotions, and ulcer is one of its common organic diseases, highlighted by the war. What has psychosomatic medicine taught us in regard to peptic ulcer?

Cushing,[2] in a noteworthy paper, observed that all clinicians are familiar with these facts: (1) that highly strung persons are particularly susceptible to nervous indigestion and associated ulcer; (2) that ulcers become symptomatically quiescent or even tend to heal when patients are put mentally and physically at rest; and (3) that the symptoms are prone to recur as soon as the victim of the disorder resumes his former tasks and responsibilities. He concluded by suggesting that highly strung (vagotonic) persons subjected to emotional stress, and such other factors as irregular meals and excessive use of tobacco, are prone to have chronic digestive disturbances often leading to ulcer. This was as far as he felt that we could go, with the data at hand, in interpreting the "neurogenic" origin of peptic ulcer and explaining its existing prevalence.

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* Read at the Seventeenth Annual Scientific Assembly of the Society, October 2, 1946.

NEUROGENIC FACTORS

From his observations and the investigations of others Cushing undertook experimental studies which showed that intraventricular injections of pilocarpine or pituitrin caused in man an increase in gastric motility, hypertonus and hypersecretion leading to retching and vomiting which ultimately contained occult blood. Following through with Cushing's observations, his associates, Light, Bishop and Kendall,[3] regularly produced peptic ulcers in animals with small intraventricular injections of pilocarpine and observed pathologically a local anemia of the stomach mucosa accompanied by surface hemorrhage and necrosis extending to the muscularis mucosae. Beattie[4] showed in animals that direct electric stimulation of the region of the tuberal centers in the infundibulum not only caused increased gastric peristalsis but also led to small hemorrhagic ulcers of the mucous membrane near the lesser curvature. After section of the vagi these gastric effects were not obtained. In a study primarily undertaken to investigate the heat regulating mechanism of the brain stem in cats, Keller[5] produced bilateral lesions in the expectation of freeing the hypothalamus from its connections with the brain stem. Postmortem studies showed gastric lesions ranging from simple hyperemic areas to erosions extending through all the layers of the gut, and to punched-out perforating ulcers.

From these studies Cushing observed that the reaction of the stomach to intraventricular injections of either pilocarpine or pituitrin in man and to direct stimulation of the tuber or its descending fiber tracts in animals is hypersecretion, hypermotility, and hypertonicity, especially marked in the pyloric segment.

Stewart Wolf and Harold Wolff,[6] in a study of a modern Alexis St. Martin, a man with a large gastric fistula whose mucosa was readily accessible to view, made noteworthy observations regarding the relationship of feeling states and changes in gastric mucosa. Emotional conflict involving anxiety, hostility and resentment was accompanied by accelerated acid secretion, hypermotility, hyperemia and engorgement of the gastric mucosa resembling "hypertrophic gastritis." It was associated with gastrointestinal complaints of the nature of heartburn and abdominal pain. Intense sustained anxiety, hostility and resentment were found to be accompanied by severe and prolonged engorgement, hypermotility and hypersecretion in the stomach. In this state mucosal erosions and hemorrhages were readily induced by even the most trifling traumas, and frequently bleeding points appeared spontaneously as a result of vigorous contractions of the stomach wall.

Contact of acid gastric juice with such a small eroded surface in the mucous membrane resulted in accelerated secretion of acid and further engorgement of the whole mucosa. Prolonged exposure of such a lesion to acid gastric juice resulted in the formation of a chronic ulcer.

Their studies suggest "that the chain of events which begins with anxiety and conflict and their associated overactivity of the stomach and ends with hemorrhage or perforation is that which is involved in the natural history of peptic ulcer in human beings."

For the purposes of the present discussion, it is noteworthy that von Bergmann[7] in Germany and Alvarez[8] in America have insisted upon the importance of nervous and emotional factors in their relation to ulcer formation. Alvarez called our attention to a certain type of individual who is particularly prone to develop peptic ulcer and referred to him as a keen, nervous, active, hard-living individual, upon whom surgeons are reluctant to operate because of the danger of recurrence of ulcer. He felt that arterial spasm may be one of the links between the emotions and ulcer formation and concluded that most ulcers are due basically to emotional factors and nervous tension. Alvarez has gone a definite step beyond the usual medical approach, which is considered complete if it enumerates the physical and chemical data concerning the patient. However, there are many patients with ulcer in whom evidence of continued worry or emotional stress cannot be so easily obtained, and those clinicians interested in the "neurogenic" aspect of ulcer pathogenesis have been forced to stop at this point in their investigations. In other words, although a distinctive psychosomatic pattern of hypersensitivity, hyperirritability and hyperactivity has been ascribed to peptic ulcer patients, these characteristics are often so masked that there are no external manifestations of mental agitation.

The next step, and the one to which we particularly call attention, depends upon the necessity for understanding that forceful influences exist in the unconscious mental life and that these may play a part in causing peptic ulcer.

Psychosomatic Studies

In our studies on patients with peptic ulcer we think (1) of the individual, "what kind of person is he?" (predisposition, physical and psychologic); (2) of the environment, "what has he met?" (tobacco and food, social and psychologic problems); and (3) of mechanism, "what happened?" (vascular supply, hyperacidity, hypermotility, etc.)

Here the emotional factor is an integral part of the study, one of the many and diverse causative factors, emerging at various levels of the personality development. The psychologic study of patients suffering from ulcer has brought out important facts about them. As Alexander[9] has shown, they apparently are burdened by certain characteristic conflicts which they are unable to resolve. What appears outwardly to be a hard-driving, active, efficient go-getter proves actually to be an insecure, dependent man whose unsatisfied cravings for love and dependence on others cannot be accepted because they are too humiliating to him. They don't correspond to the picture he has of himself. He tries hard to compensate for his essential weakness. Indeed, he will often overcompensate for it. When his ambition is thwarted or his efforts toward success and accomplishment and leadership are too challenging, his stomach, so to speak, rebels. There is reason to believe that these passive, receptive cravings, when not satisfied—as they can hardly be in an individual whose conscious life is so consecrated to activity and success—find their expression in a primitive way. Just as anger and fear and pain may express themselves in the form of trembling and pallor and swearing, so the need to be loved and cared for, when denied, may express itself as a desire to be fed. The stomach is then constantly alerted and behaves as it does during digestion, continuously prepared for food that it does not receive.

This phenomenon depends upon infantile habit formations which serve as a pattern of behavior later in life. Alexander explains that the first form of being cared for and loved is nursing and the sensations of being loved and being fed become emotionally associated for the rest of life. If the wish to be loved, as one was by the mother, is denied gratification (repressed) the associated tendency for being nourished is energized.

It might be said that just as sustenance and sensuality are associated in the life of the infant, so bed and board are associated in the life of the adult.

Draper,[10] long a protagonist of disease as a "psysomatic" reaction, pointed the way to a deeper psychologic understanding of personality in relation to peptic ulcer by calling our attention to the unconscious mental life in his studies of patients with ulcer. But it was Alexander who developed the idea that permanent psychic stimuli from unconscious mental sources may be capable of stimulating the subcortical centers similarly to the direct irritations observed by Cushing and others. This constant psychic stimulation of subcortical centers apparently produces local functional disturbances in the upper digestive tract that may be followed by ulcer formation. The following case illustrates some of the points mentioned.

A white man, 35 years old, had indigestion off and on over a period of 15 years. In August, 1932, there was a large hemorrhage from the stomach and he was rushed to the hospital. Appropriate treatment brought about quick recovery, and studies later demonstrated a well marked duodenal ulcer. There were no other medical facts of importance connected with his previous history. When questioned about worry or emotional stress he answered that his only worry was indigestion; he was successful in business and contented at home.

He was a keen, hard-working, business man; unmarried, living with his family, consisting of father and mother, 2 sisters and 1 brother. The sisters were 29 and 23 years old, the brother 27, all unmarried. The patient contributed generously to the support of the family.

The mother was an energetic and capable woman who indulged her family and watched over the children unceasingly. Indeed, she still exercised a great influence over the life of the patient. The father was an easygoing, indolent person, apparently little interested in the family, who took little interest in him.

The mother recalled that as a youngster the patient was "a good boy" and very studious. His grades in school and college were excellent; he took part in many extracurricular activities although he did not enter into athletics. He had some indigestion during his college days at the time of an unsuccessful love affair. It disappeared and returned while he was in a training camp in 1918. Since that time he had been bothered off and on.

For the last 4 years he had been very attentive to an attractive young woman, and, although obviously devoted to her, when questioned about marriage, he said: he was comfortable at home and didn't want to change; he wanted to be free to pursue his own life as he saw fit; he had seen many unfortunate marriages; he had to contribute to the family support (although his support was not essential to them). More reasons were given which, like the others, could be readily recognized as rationalizations. Somewhat casually he remarked that his mother was not in favor of the marriage. Nevertheless, he apparently was deeply impressed by his mother's objection to the girl. Her stated objection was that she did not consider the girl his social equal (although they themselves were of humble origin). During the last several years while at home he had been relatively free from indigestion and almost entirely free during the last year and a half—a period of freedom from indigestion which coincided with the attainment of financial success and also with a period in which his mother no longer voiced objections to his companion. The hemorrhage came quite suddenly after what he said was a period of hard work and dietary indiscretion. It was also to be noted, however, that his closest friend, who had experienced marital difficulties and had always advised the patient to stay single, attempted suicide at that time, apparently because of marital reasons.

The picture of this man was that of an energetic, hard-working, "successful" person with marked repressions and retarded emotional development, indicated by his strong attachment to his mother, afraid to face marriage and compromising the situation by maintaining an engagement for an indefinite period, meanwhile giving a great many reasons, which were obviously not good reasons, for avoiding marriage. Apparently the affair produced a conflict between his attachment to his mother and his desire to establish an independent home and to attain a proper masculine (heterosexual) goal.

His deference to his mother's wishes and his attitude of excessive morality and goodness indicated unconscious strivings of passivity and dependency, while his energetic pursuit of business and his indefinite "engagement" to a girl to whom his mother objected indicated his conscious efforts at accomplishment and independence. Such a conflict refuted his denial of any worry or stress apart from indigestion and showed how necessary an understanding of unconscious strivings was to appreciate the forceful psychic influences that were at work in this patient.

Such studies replace the loose terminology "neurogenic factors," "large nervous element," etc., and the vague thinking behind such terminology, with a more complete and more precise definition of the mental mechanisms that may be concerned in ulcer formation. This does not mean that we believe that psychologic factors are the only ones of importance in peptic ulcer. It is quite obvious that peptic ulcer may occur quite devoid of psychologic factors, for example, the ulcers that are discovered in infancy and early childhood when the conflicts that I have discussed could not possibly enter. But this does not rule out the importance of the psychologic factor in the usual adult case, where, as stated before, the emotional factor is one of the multiple factors which act in a complementary manner to bring about the ulcer.

Treatment Considerations

In utilizing the psychosomatic approach from the standpoint of treatment we must concentrate upon the patient as a person rather than upon the ulcer as a disease. We must try to discern the major motivations of the patient's life, his feelings, tensions and conflicts. We must be especially alert to his needs for love, dependency and support, and we must be aware of any frustrations of these desires. Now when we make the patient understand his problem, he himself will often have ideas for environmental changes and will often endeavor to alter his attitude. This of course is the essence of the matter—that the patient must be helped to see his problems differently and to act upon them rather than to have the physician take the full responsibility in these matters.

Our studies suggest then that the viewpoint of Rokitansky, almost a hundred years ago, who believed that the cause of peptic ulcer was "a diseased innervation of the stomach, owing to a morbid condition of the vagus, and to extreme acidification of the gastric juice" may indeed be valid. Certainly it is in line with the most recent surgical approach, namely, vagotomy.

My only point in this regard would be that if these powerful psychologic forces of which I have spoken are denied an outlet in the stomach or duodenum as a result of vagotomy, how then are they to express themselves? Will they not, like steam under pressure, exert evil effects upon other parts of the organism? It seems to me that such psychosomatic studies must be made on patients who have been operated upon, and they suggest that, whatever the surgical approach, some psychologic evaluation of the man who has the ulcer still must be made.

BIBLIOGRAPHY

1. Weiss, E., and English, O. S.: Psychosomatic Medicine Philadelphia: Saunders, 1943.
2. Cushing, Harvey: Peptic ulcers and interbrain (Balfour lecture). Surg. Gynec. & Obst., 1932, **55**, 1.
3. Light, R. U., Bishop, C. C., and Kendall, L. G.: Production of gastric lesions in rabbits by injection of small amounts of pilocarpine into cerebrospinal fluid J. Pharmacol. & Exper. Therap., 1932, **45**, 227.
4. Beattie, J.: Relation of tuber cinereum to gastric and cardiac functions; preliminary note. Canad. M. A. J., 1932, **26**, 278.
5. Keller, A. D.: Ulceration of digestive tract caused by experimental lesions of hypothalamic region. Tr. American Physiological Society, Philadelphia, April 30, 1932.
6. Wolf, S., and Wolff, H. G.: Evidence on genesis of peptic ulcer in man. J. A. M. A., 1942, **120**, 670.
7. von Bergmann, G.: Zur Pathogenese des chronischen Ulcus pepticum. Berl. klin. Wchnschr., 1918, **55**, 524; Mitt. a.d. Grengeb. d. Med. u. Chir., Suppl., 1923, **4**, 20.
8. Alvarez, W. G.: Light from laboratory and clinic on causes of peptic ulcer. Am. J. Surg., 1932, **18**, 207.
9. Alexander, F.: Influence of psychologic factors upon gastrointestinal disturbances. Psychoanalyt. Quart., 1934, **3**, 501.
10. Draper, G., and Touraine, G. A.: Man-environment unit and peptic ulcer. Arch. Int. Med., 1932, **49**, 616.

BENADRYL FOR IVY POISONING*

A Preliminary Report on Its Use in 14 Cases

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BENADRYL,† a chemical compound synthesized by Rieveschl and Huber, is being used clinically in many dermatologic conditions in which pruritus is a major symptom. The first clinical report, by Curtis and Owens,[1] seemed to show excellent results in acute and chronic uriticaria. These results have been confirmed by several subsequent authors, O'Leary,[2] Todd,[3] Shaffer,[4] and by our own results.[5]

Loew[6] demonstrated that benadryl exerted a marked antihistamine effect in guinea pigs. Lewis[7] believed that a diffusible histamine-like substance is responsible for the triple response seen in the skin in urticaria and dermographism. He also believed that the skin liberated this histamine-like substance as a response to any abnormal irritation. The results so far reported with the use of benadryl lend support to this theory.

One of the most common pruritic affections of the skin is that due to poison ivy, a contact dermatitis. In this condition there is an abnormal irritation of the skin which could cause release of a histamine-like substance as postulated by Lewis. It was thought that benadryl might be useful to reduce the pruritus of ivy poisoning and allow the lesions to heal.

We have had the opportunity to observe the action of benadryl in 14 cases of ivy poisoning this summer (table 1). Most of the patients had received local therapy to the lesions for several days before the institution of benadryl treatment. Four of the patients continued to use the local medication, whereas 10 used no further drugs locally after onset of benadryl treatment. The local treatment made no difference in the ultimate results after benadryl was started.

TABLE 1

CASE NO.	DAYS AFTER ONSET OF SYMPTOMS		
	Beginning of Benadryl Treatment	Symptoms Controlled without Benadryl	Disappearance of Rash
1	4	7	7
2	4	5	5
3	1	3	5
4	1	4	11
5	1	2	9
6	1	4	12
7*	1	5	10
8	1	4	9
9	3	7	13
10	2	5	11
11*	5	8	14
12	3	5	12
13	7	11	15
14	2	5	14

* Symptoms only moderately controlled.

Of these 14 cases, 12 received marked relief from the associated pruritus for periods varying from 4 to 8 hours after each dose. These patients could be maintained symptom-free on 50 mg. doses of benadryl orally every 4 to 6 hours. Two patients received moderate relief after treatment with benadryl.

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† Beta Dimethylaminoethyl Benzhydryl Ether Hydrochloride.

We have recently obtained an experimental supply of benadryl solution for intravenous administration.* In the course of our studies of this preparation we found that we could readily determine whether or not a patient would respond to benadryl by testing its antipruritic effect when given intravenously. Thirty mg. of benadryl was diluted with 100 c.c. normal saline solution and administered intravenously over a period of 10 minutes. If relief of symptoms was noticed at the end of this time we felt reasonably sure that the patient would respond to benadryl orally. This proved to be the case in the last 2 patients in this report.

ILLUSTRATIVE CASE

O. W. N., a 12-year-old white boy, had been walking in the woods with his mother. Two days later he developed a vesicular rash with pruritus which rapidly spread over his extremities, trunk and scrotum. The patient was first seen 2 days after the onset of the dermatitis. Fifty mg. of benadryl orally gave marked relief from the pruritus in 30 minutes, and the effect lasted 8 hours. This dose was repeated twice the following day. Three days after beginning treatment with benadryl the rash had completely subsided. The mother of the patient also developed dermatitis venenata at the same time, but her dermatitis was limited to the extremities and was milder. She did not use benadryl. Her lesions persisted for 10 days.

SUMMARY AND CONCLUSIONS

Fourteen patients with contact dermatitis with pruritus were treated with benadryl. Twelve obtained marked symptomatic relief, and in 2 the relief was moderate. The lesions stopped spreading soon after the beginning of treatment in 3 patients and entirely cleared within a period of 72 hours. The treatment did not alter the usual course of the rash in the other 11 patients even though the symptom of pruritus was controlled.

The action of benadryl, an antihistaminic, in these cases lends support to the theory as introduced by Lewis[7] that a histamine-like substance is liberated at the site of skin irritations.

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BIBLIOGRAPHY

1. Curtis, A. C., and Owens, B. B.: Beta-dimethylamino-ethyl benzhydryl ether hydrochloride (benadryl) in treatment of acute and chronic urticaria. Univ. Hosp. Bull., Ann Arbor, 1945, **11**, 25.
2. O'Leary, P. A., and Farber, E. M.: Benadryl in treatment of urticaria. Proc. Staff Meet., Mayo Clinic, 1945, **20**, 429.
3. Todd, L. C.: Urticaria—with observations on use of new antihistamine drug, benadryl. South. Med.. & Surg., 1946, **108**, 1.
4. Shaffer, L. W., Carrick, L., and Zackheim, H. S.: Use of benadryl for urticaria and related dermatoses; preliminary report. Arch. Dermat. & Syph., 1945, **52**, 243.
5. Blumenthal, L. S., and Rosenberg, M. H.: Benadryl: preliminary report on its use in 39 patients. M. Ann. District of Columbia, 1946, **15**, 478.
6. Loew, E. R., Kaiser, M. E., and Moore, V.: Synthetic benzhydryl alkamine ethers effective in preventing fatal experimental asthma in guinea pigs exposed to atomized histamine. J. Pharmacol. & Exper. Therap., 1945, **83**, 120.
7. Lewis, T.: The Blood Vessels of the Human Skin and Their Responses. London: Shaw & Sons, 1927. Pp. 322.

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* Supplied through the courtesy of Dr. E. A. Sharp of Parke, Davis and Company.

President's Page

WHAT YOUR SOCIETY OFFERS

Your Society is an active organization and always working for you. The scope of its activities is not generally appreciated even by our membership. Here are some of them:

Two informative, high-caliber, scientific meetings are presented monthly from October to May to keep you abreast of the most recent advances in medical science. Postgraduate lectures are offered each spring by the Committee on Postgraduate Education for a very nominal fee. The Annual Scientific Assembly held each year has become one of the best meetings of its kind in the country. The Davidson Lecture, always an outstanding scientific event, is presented every other year. The Sections on Ophthalmology, Otology, Rhinology, and Laryngology; Neurology and Psychiatry; Pathology and Laboratory Medicine; Gastroenterology; and Pediatrics provide additional programs for the members of the Society. Soon these will be augmented by Sections on Anesthesiology and General Medicine.

Our medical journal, Medical Annals of the District of Columbia, one of the best state medical journals in the country, is published and distributed to you at no additional cost.

The Committee on Public Health carries an ambitious program in coöperation with the official and voluntary health agencies in the District of Columbia. Radio talks are presented weekly over Station WOL by Dr. James A. Gannon, a member of the Committee on Radio Education. The Speakers' Bureau is functioning again under the direction of the Committee on Public Relations. Medical Bureau renders twenty-four hour service to citizens of the District and keeps you in touch with them under several different arrangements, one of which actually makes the Bureau your secretary.

Representatives of the medical, dental, nursing, pharmaceutical, and hospital organizations of Washington are now participating in what is known as the Interprofessional Conference. The Conference was organized for the purpose of considering mutual professional problems largely through the efforts of your Society. The Federation of Citizens' Associations, District Traffic Advisory Board, Washington Council of Social Agencies, Washington Board of Trade, and the Washington Metropolitan Health Council are among the other organizations in which your Society officially takes part.

Medical Service of the District of Columbia, the Society's medical service plan, is just about to get under way. Your officers are confident that the Service will render a highly satisfactory public service.

As most of you know, the Society has arranged for group malpractice and health and accident insurance coverage for its members.

An agreement was recently entered into with the Veterans Administration. When local Government medical facilities become inadequate, members will render service to veterans under an equitable fee schedule.

Cards for special parking privileges when on emergency calls may now be had at the Secretary's office as a result of an agreement with the Department of Vehicles and Traffic and the Metropolitan Police Department.

In addition to the aforementioned benefits, I am sure everyone knows that the Society's Secretary, Theodore Wiprud, and his assistant, J. Richard Connelly, are at the service of members at all times, day or night.

In concluding this month's message, I should like to leave with you the fact that in so far as annual dues are concerned, they are among the lowest in any metropolitan area. It is hoped that they can be maintained as they are, in view of the growth of our membership. I personally wish to assure each and every member of the Society that I am receptive to any suggestions that will make our Society of more benefit to members and to the community.

William P Herbst Jr

Editorials

MEDICAL GROUP PRACTICE*

For many years, notably since the report of the Committee on the Costs of Medical Care in 1932, there has been considerable sporadic discussion of group practice. At present, interest in this kind of medical practice is unprecedentedly intense and widespread, as shown by the replies from physicians in the armed forces to the American Medical Association questionnaire (52 per cent indicated that they wished to engage in private group practice after the War), and by the frequent requests for information received by the American Medical Association, the U. S. Public Health Service, and by existing successful groups.

One of the difficulties encountered both by those who wish to start a group and by those to whom they turn for advice is that factual information about group practice is meager and scattered. The U. S. Public Health Service, hoping to develop a body of information which will be useful both to discussants and to practitioners of group practice, is currently engaged in a study of the subject. Publication of the collected material will begin soon.

It is now possible, however, to make a few general observations. The first concerns the definition of group practice. In the absence of any generally accepted definition, everyone who discusses the subject must set up his own standards. As the term is used here, it is given a fairly broad interpretation, and includes any formal organization of three or more physicians who practice together as their principal professional activity. The group may be a partnership of the practitioners, or the members may be employed by a single owner, by an industrial company, by a hospital, or by a coöperative or other association of prospective patients.

It has been found useful to differentiate between "reference groups," whose principal activity is the furnishing of specialized care to patients referred to them by outside physicians, and "service groups," whose principal activity is the furnishing of complete medical care to a continuing clientele. Few groups are exclusively "reference" or "service," but the distinction on the basis of "principal activity" has been of great importance in understanding and interpreting many of the aspects of group practice. Large reference groups whose membership includes eminent specialists have an established and unquestioned place in American medicine, and arouse little or no controversy. The principal controversial question about group practice is whether service groups can function efficiently to provide all of the medical care required by a segment of the population. Related to this is the question concerning the place of the general practitioner in group practice.

There are a number of problems which a given group must solve if it is to succeed. One of the most important is that of achieving proper coördination of the professional work of the members and of avoiding friction in either professional or financial matters. There are differences of opinion as to the degree to which coördination of work should be carried, and the means by which it is obtained. Some groups have a medical director who supervises the work of all of the members; others maintain little or no direct supervision of the work of the individual physicians, and rely on each member's spirit of coöperation to achieve the desired coördination of work. As to policy decisions, some groups permit all of the members to participate, while others feel strongly that the tone and policy of the group must be set by one or, at the most, two or three leaders.

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* This is the twelfth in a series of guest editorials by distinguished physicians and laymen. Others to follow will deal with the scientific, social and economic aspects of medicine.

In private groups, the distribution of income is of basic importance to the success or failure of a group, and a great variety of schemes have been worked out to solve the problem. Ideally, the method of income distribution should reward each member properly for his skill, industry, and professional value to the group and its patients, and should not discourage the proper use of intragroup referral and consultation. The multiplicity of schemes for income distribution suggests that the ideal has not yet been achieved, though some of the plans seem to be reasonably satisfactory in both respects.

Another basic problem is that of the continuity of the group. If a group is to remain in existence indefinitely, it must make provision for acquiring new members and for retiring old members, and must set up machinery for the equitable handling of capital assets. Many groups have found it advantageous to set up a dual organization, with a partnership for the practice of medicine, into which new members can be admitted without the necessity of making an investment, and a corporation for the ownership of physical assets, in which members hold stock in proportion to their investment. There are usually provisions that any partner may buy into the corporation, and that no corporation stock can be held by any person not a partner. If it is properly set up and administered, such a dual organization effectively separates the practice of medicine from the details of investment and ownership, and is especially valuable if the group owns a hospital.

This brings up another problem, whether it is advisable for a group to own a hospital. Among physicians practicing in groups, there is considerable difference of opinion on this score. It is probable that the question cannot be answered categorically, and that the proper answer is determined by the circumstances confronting each specific group.

The study now being carried out by the Public Health Service is designed to collect facts which will throw light on some of these problems, and permit a more objective approach than is now possible.

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THE GLYCOSIDES OF DIGITALIS

The currently growing swing to the popular use of purified crystalline digitalis derivatives of great potency is a natural development in the history of that wonderful plant, the foxglove. First used as part of a mixture of herbs, later as the unstable tincture, and then as the powdered whole leaf, the effective constituents of digitalis are now readily available in crystalline form. A large number of closely similar substances, derived from widely different sources in nature, are known now to act upon the failing heart muscle. They vary more or less as to their degrees of absorbability from the alimentary tract, rapidity and duration of effect on the circulation, rate of excretion, and toxicity in effective dosage.

The principles for using these preparations (grouped together as cardiac glycosides) include those laid down by Withering, Wenckeback, MacKenzie, Luten and others who wrote about the cruder preparations. One must still evaluate the patient and his disease as to its severity and variable phases. One must still expect differences between patients as to optimum dosages for digitalization and maintenance. One must still cope with the patient who omits or adds to his prescribed dose according to whim or his sense of well-being from day to day. One must still be alert to recognize overdosing, sensitivity, cumulative toxicity, and need for other treatment. We cannot yet claim to have a digitalis-like remedy of significant effectiveness but without possible harmfulness. Each of the present forms may be of value if used with understanding but each will be dangerous otherwise.

Nowadays we cannot relax with the old dictum, "Learn to use one brand of digitalis well and forget about the others." Each physician is likely to meet patients who have been given treatment with any of the newer or old preparations. We must be moderately familiar with each of the digitalis preparations now popular if we are to avoid harming some patients and if consultations are to be most helpful. For example, the common query, "Have you been taking any little brownish-grey pills or green liquid?" will not detect a patient's use of pink or white Digitaline Nativelle.

Patients treated with digitalis derivatives should be provided with a pocketbook card, such as is generally given diabetic patients. This card would give valuable information to the doctor or hospital called upon to treat the patient in an emergency. This information would often clarify the difficult problem of whether a new patient needs more digitalis or is suffering from too much of the drug. This card might be printed like this:

FOR EMERGENCY USE:

I am being treated for a weak heart. My doctor or clinic is:..

at..............................; Phone:..........

I am taking digitalis in the form of:..........................

....
(Trade name)

with initial dose of .... on ....
(date)

and daily dose of..

In trying to select a digitalis preparation for general usage one may be confused by the counter claims of various authors or pharmaceutical houses. Digitalline Nativelle, isolated in 1858 by Nativelle in France, was the first effective crystalline derivative. Only in the past few months however has this material been obtainable in amounts large enough to make it available for general use. It is believed to be the pure substance, digitoxin, which chemically is the name given the final derivation of glycoside A from either *Digitalis purpurea* or *Digitalis lanata*, the two most used species of the foxglove. Digitoxin is now sold by several firms, sometimes under trade names such as Purodigin or Crystodigen. This preparation is absorbed entirely and quickly from the alimentary tract. It is stable, and may be given in a single oral dose large enough for full digitalization without fear of toxic effects. It is excreted rather slowly and maintains its effect almost as long as digitalis folia. Therefore, in cases of overdosage, toxic effects may be expected to last two to three weeks. It seems to be a safe and reliable preparation for oral or intravenous digitalization, in single or divided doses and for maintenance. In cases of great urgency, however, it may be less desirable than several available preparations with more rapid onset of action.

Digoxin and Cedilanid, each a crystalline form of glycoside C derived from *Digitalis lanata*, are effective more quickly than digitoxin after intravenous injection. They approach strophanthin in rapidity of action but have a greater margin of safety between therapeutic and toxic doses. Digoxin has a more prompt action than Cedilanid and is not excreted quite so rapidly, although both exceed Digitoxin in these features. The rapidity of excretion has a potential value, in that intoxication is usually of shorter duration, but it also makes maintenance likely to be more difficult. The absorbability of Digoxin seems to be about 100 per cent, as with Digitoxin, so that its use orally is feasible. Cedilanid on the other hand resembles the whole leaf in that its absorbability is about 10 per cent to 20 per cent and, worst of all, may be rather unpredictable. Therefore, oral use of Cedilanid at present is not as valuable as with Digitoxin or Digoxin.

Cedilanid has been used with safety and decided value in full intravenous dosage given to some patients already digitalized who developed recurrence of congestive failure. A good explanation of this phenomenon is lacking, but this observation of LaDue seems to be correct. Probably the result is due to failure of full absorption of previous digitalis by the congested intestinal mucosa or by fixation in a congested liver. Digoxin and Digitoxin may be tried in a similar way.

With the crystalline glycosides one must still expect to find cases in which the need for the drug is greatest, but in which susceptibility to toxicity is also excessive. For example, this dilemma is met often with patients having congestive failure plus myocardial infarction, acute rheumatic or other myocarditis. Here a great nicety of judgment, with balance of caution and boldness, is called for. Intramuscular injection is effective, though less reliable, when oral and intravenous routes are not available. Subcutaneous injection is always contraindicated. Rectal suppositories or solutions of digitalis principles may be useful occasionally.

Gitalin is a derivative of glycoside B which has not yet received much popular clinical usage. Digilanid is a mixture of the purified lanatosides A, B, and C which has been used widely with good effect orally and intravenously. It does not seem likely that such a mixture of glycosides has any advantage over a single purified crystalline glycoside.

Some valuable cardiac glycosides are made from other sources than digitalis. Although less often needed, they may be life-saving at times. Strophanthin (Ouabein) has the most rapid and transient action and the smallest margin of safety of all the cardiac glycosides. It may be used intravenously in cases in which death from congestive failure appears imminent within a matter of minutes. Its widespread usage has no justification now. Squill and other sources of cardiac glycosides may be called for on rare occasions where a patient cannot or will not take digitalis in any preparation, for psychologic or other reasons. Quinidine is of remarkable help in ventricular tachycardia, some supraventricular tachycardias and flutters, and possibly in other states of myocardial irritability. Its high toxicity must be guarded against by very close supervision.

There are many preparations of digitalis leaf which are partially purified. These probably contain less of the saponins, fats and other components of the leaf which are not of great value to the failing heart and which are believed to cause most of the nausea, vomiting and diarrhea. These preparations have served a role in the development of pure crystalline glycosides but will probably be replaced soon by the latter. In this group are Digifoline, Digalen, Digitan, Digifortis and many other brands. Each of these can still be used with good effect in skilled hands, just as was possible with the older tinctures, fluid extracts or powders of the whole leaf. They are standardized biologically, however, in cat or frog units, which have an unpredictable relation to human units and metric dosages.

With the crystalline glycosides one knows that a milligram ordered represents a milligram of the effective material rather than a milligram of leaf powder containing an unknown amount of effective substance. This is one of the goals of pharmacognosy, which when attained removes the need for biological standardization. Reference to "cat units" should not be employed now in prescribing the glycosides.

A new era is beginning in therapy with digitalis. Our greatest need now is a simple test for blood levels of these substances, and a quick method of alleviating toxic effects.

Table 1 lists recommendations for using some of these preparations.

Joseph T. Roberts, M.D.

TABLE 1

The Use of Cardiac Glycosides

(For adult patients with congestive or impending heart failure, with no digitalis in the two preceding weeks.)

DRUG AND BRANDS	TABLET SIZE	AMPULE SIZE	DIGITALIZATION DOSE	MAINTENANCE DOSE (DAILY)
Digoxin (Burroughs Wellcome)	0.25 mg. (white)	0.5 mg. = 1 c.c. (Irritant out of vein; dilute with 10 c.c. isotonic solution.)	0.75–1.5 mg. initially by mouth or vein plus 0.25 mg. at 6-hour intervals until desired effect (ventricular rate of 70) or toxicity begins.	0.25–0.75 mg.
Digitaline Nativelle (Varick), Purodigin (Wyett), Cardodigin (National), Crystodigin (Lilly), and other brands of Digitoxin (Squibb, Abbott, et al.)	0.1 mg. (pink) or 0.2 mg. (white)	0.2 mg. = 1 c.c., 0.4 mg. = 2 c.c.	1.0–1.6 mg. (average, 1.2 mg.) by mouth or vein initially, as a single dose, or divided over 1 or more days; plus 0.2 mg. at intervals of 12 hours or more until desired effect or toxicity begins.	0.1–0.3 mg.
Cedilanid (Lanatoside C, Sandoz)	0.5 mg. (pink)	0.4 mg. = 2 c.c., 0.8 mg. = 4 c.c.	By vein, 1.6 mg. in single or divided doses. By mouth, 5–7.5 mg.	By vein, 0.4–0.8 mg. By mouth, 0.5–2.0 mg.
Digilanid (Sandoz)	0.33 mg.	0.4 mg. = 2 c.c., 0.8 mg. = 4 c.c.	By mouth, 3.0–7.3 mg. in divided doses over 1–5 days. By vein, 0.8 mg.	0.33–0.66 mg. by mouth or vein.
Digifolin (Ciba)	1 cat unit or 0.1 Gm.	0.1 Gm. = 1 c.c.	By vein, 0.03 c.c. per lb. of body weight, plus 0.017 c.c. per lb. at 2-hour intervals until effect or toxicity begins. By mouth, 1.4 Gm. in first day in single or divided doses; or 0.1 Gm. every 4–6 hours until effect appears.	By vein, 0.1–0.2 Gm. By mouth, 0.1–0.3 Gm.
Digalen (Hoffmann-LaRoche)	½ and 1 cat units, (1 cat unit = 80 mg. of Digitalis Ref. Standard, 1942)	2 c.c. = 1 cat unit = 81 mg. U.S.P. Digitalis Reference Standard, 1942.	By vein, 8 c.c., repeated in 2–4 hours, plus 2 c.c. every 4–24 hours until effect or toxicity appears. By mouth, 14–27 cat units in divided doses over 1–7 days, until effect appears.	By mouth or vein, ½–2 cat unit.
Strophanthin	Not effective	0.5 mg.	By vein, 0.4–1.0 mg. Not more than 0.5 mg. per dose; repeated after 6–24 hours if needed or continue with digitalis in smaller doses than usual.	By vein, 0.25 mg.–0.5 mg. Seldom used in the U.S., but commonly used in Europe.
Squill (Scillaren, Sandoz)	0.8 mg.	0.5 mg. = 1 c.c.	By vein, 0.5–1.0 mg. By mouth, 15–30 mg.	1.0 mg.

PREVENTION OF RECURRENCES OF PEPTIC ULCER

It is hard to think of a disease that responds more satisfactorily to treatment than an uncomplicated peptic ulcer. A wide variety of methods of medical management have been devised, and almost all of them are good, in the sense that they promote more or less prompt healing. A few years ago an editorial in the ANNALS[1] pointed out that something more is needed than a regimen for initial healing, that a long-term program for keeping the ulcer "healed" is required. There was nothing original in this idea. The discouraging tendency of peptic ulcer to recur has been recognized as one of its most distinguishing features for many years.

One of the medical technics for prevention of recurrence depends principally upon so educating the patient that he will be able to anticipate the needs which arise for added care.[2] Conditions and situations which aggravate the tendency to recurrence are avoided when possible. This implies that tobacco, alcohol, and caffeine-containing beverages are permanently interdicted; that the habit of taking milk and cream at 10 a.m., 3 p.m., and bedtime becomes lifelong; and that a method of living "calmly" is sought. When emotional strains or illnesses known to predispose to recurrence are encountered the patient takes feedings frequently and uses antacids more vigorously. In this connection Alvarez[3] emphasizes that the extra feedings and doses of antacids are most important between the hours of 10 p.m. and 3 a.m.

In a recent reappraisal of the problem of peptic ulcer, Ivy[4] makes it clear that he expects little from the kind of regimen just outlined. He doubts that the majority of ulcer patients will adopt a "calm life" and follow a routine of strict management. Here is a strong implication that the ulcer patient cannot be reëducated. This certainly constitutes a challenge that can hardly be refused by those who are interested mainly in the psychiatric aspects of the problem. Ivy believes "that the most promising approach for the solution of the problem of the prevention of recurrences of peptic ulcer is to find some therapeutically practical and innocuous method for increasing the resistance of the mucosa to injury and for completely blocking the parietal cell" (the producer of hydrochloric acid). He thinks it possible that the use of enterogastrone may be the answer. This substance is produced by the intestinal mucosa and has the power to inhibit gastric secretion and motility. It tends to abolish the gastric secretory response to histamine. The preliminary report on the clinical use of enterogastrone is too sketchy to permit any kind of conclusion. However, the logic behind its use certainly justifies a thorough trial.

Until recently the only satisfactory surgical approach to the problem of prevention of recurrences of peptic ulcer has been subtotal gastrectomy. This method has been used extensively enough to be sure that it is effective in the great majority of cases when it is properly done. Moreover, in skilled hands, it is attended by a low mortality rate and by a surprisingly low incidence of gastrointestinal symptoms attributable to the operation itself. However, it is a procedure of such magnitude and, in a sense, so destructive that it can hardly be expected that it will be used routinely.

We are indebted mainly to Dragstedt[5] for a new surgical method, supradiaphragmatic vagotomy. Division of the vagus nerves to the stomach abolishes gastric hypermotility and hypersecretion and promptly relieves ulcer distress.

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[1] Hussey, H. H.: M. Ann. District of Columbia, 1943, **12**, 113.

[2] Smith, L. A., and Rivers, A. B.: J. A. M. A., 1943, **122**, 209.

[3] Alvarez, W. C.: Ibid., 1944, **125**, 903.

[4] Ivy, A. C.: Ibid, 1946, **132**, 1053.

[5] Dragstedt, L. R.: Surg., Gynec., & Obst., 1946, **83**, 547.

[6] Thornton, T. F., Storer, E. D., and Dragstedt, L. R.: J. A. M. A., 1946, **130**, 764.

[7] Weeks, C., Ryan, B. J., and Van Hoy, J. M.: Ibid., 1946, **132**, 988.

[8] Alvarez, W. C.: Ibid., 1946, **132**, 970.

Of special significance, perhaps, is the reduction in continuous nocturnal gastric secretion, a factor presumed to have great importance in the pathogenesis of peptic ulcer.[6] This operation is not entirely safe[7] and has some annoying effects due to gastric atony and retention.[8] This procedure promises also to prevent recurrences of peptic ulcer, but full appraisal of its value in this respect must await the passage of more time.

H. H. H.

In and Out of Focus

BY THE OBSERVER

AMA and Senate Leaders Confer

Physicians who keep abreast of legislative matters will recall that Senator Robert A. Taft introduced a health bill (S.2143) in the last session of Congress. Well aware that his bill was imperfect, Senator Taft invited criticism and suggestions. He particularly sought the advice of physicians. Of course, the legislation stood little chance of passage in the 79th Congress because the Republicans were in the minority. Now that the situation is reversed, and the new Congress is well under way, Senator Taft has let it be known that he is rewriting his health bill, and will introduce it in the near future.

About a month ago he invited AMA representatives to meet with Senators H. Alexander Smith of New Jersey, Joseph H. Ball of Minnesota, and himself. In the group representing the AMA were Dr. R. L. Sensenich, Chairman of the Board of Trustees, Dr. Ernest E. Irons, Secretary of the Board, Dr. E. L. Henderson, Chairman of the Executive Committee of the Board, Dr. George F. Lull, Secretary and General Manager, W. J. Holloway, Director of the Bureau of Legal Medicine and Legislation, and Dr. Joseph S. Lawrence of the Washington Office.

Upon Senator Taft's suggestion, the group reviewed his health bill. Several changes were suggested which were acceptable to the Senators. Principal features of the proposed bill agreed upon by those present were: (1) Establishment of a separate Government agency to administer its provisions; (2) appointment of a physician, preferably in private practice, by the President to direct the health program which the bill contemplates; (3) appointment of an Advisory Committee by the President with more than advisory powers; (4) application of means test on a state level; and (5) the administration of the program on a state level, according to plans formulated by separate states. An appropriation of $200,000,000 will be made available and apportioned among the states according to a formula similar to that contained in the hospital construction law.

Before these lines appear the Taft health bill will have been introduced in the Senate. Whether or not it has much chance of passage in this session of Congress is questionable. However, there is no doubt that health legislation of a similar nature will eventually be enacted. Physicians should therefore study the provisions of the new bill and communicate their suggestions to their medical societies or to the American Medical Association.

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The President Has Not Changed His Mind

Despite the refusal of the 79th Congress to go along with him on his health program, President Truman has not changed his mind in regard to it. If anything, he is more stubbornly resolved to convince the current Congress that he is right, and if possible to win its support. There have been indications, too, that his dislike for leaders of organized medicine is not on the wane. At least he has not sought their advice, and where they have made advances, they have been ignored.

If there was any question in the minds of physicians as to the President's feelings, it must have been dispelled by his first message to the 80th Congress. On the subject of sickness and insurance the President said: "There is an urgent need to spread the risks arising from sickness and disability by insuring workers against the loss of income and by providing, through social insurance, ready access to essential preventive and curative medical services. I have, in a previous message, presented recommendations for a program of medical care and disability benefits. I urge early consideration of this program."

While there is little likelihood of the President's health program, especially its health insurance features, being enacted by this or perhaps any other Congress, he is obviously not going to give ground. Whether one agrees with the President or not, one has to admire his determination to fight for his convictions, even though they be for a lost cause.

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Doctors and Dentists

Your Observer recalls an experience he had many years ago in a Midwestern city when he met with a group of dentists. On the program was a physician who in the course of his talk emphasized the importance of close coöperation between doctors and dentists. After the physician's departure, one of the dentists got to his feet and made some extremely caustic remarks about a physician who apparently did not know that dentists were also doctors.

Now this is a very common error and one which is frequently made by both physicians and laymen. The latter, as a matter of fact, usually think of a doctor as being a doctor of medicine. It is your Observer's impression that dentists generally do not take this too seriously. However, it does seem to have more significance than appears on the surface.

On a number of occasions your Observer has talked rather frankly with his friends in the dental profession. Many of them have a feeling that physicians generally consider them inferior professionally. Why? To begin with, physicians are reported to be of the opinion that the training of a dentist is not as extensive nor as complete as that of a medical practitioner. His general educational background, they say, is deficient. Consequently, he is more of a technician than a practitioner of the healing arts.

If these are representative views, physicians are in need of enlightenment. For the facts are these: Applicants for training in recognized dental schools are now required to have at least two years of general college work. But more than one half of the applicants at the present time are graduates of our best colleges and universities.

With respect to his professional training, the modern dentist is vastly superior to his predecessors. In addition to four years of dental training, embracing many subjects offered in medical schools, he frequently serves a hospital internship and does postgraduate work. So it can be seen that from the standpoint of his professional training, the dentist of today is no more like his counterpart of a decade ago than the present-day physician is like the practitioner of the 1920's.

Aside from their scientific interests, physicians and dentists have a great deal in common. Certainly this is true where controversial issues of the day are concerned. For example, both professions are deeply interested in newer methods of distributing health services. In fact, this problem is of such a vital nature that mutual understanding and coöperation are essential. However, a close relationship is out of the question unless there is mutual respect and confidence. So it is highly essential that doctors of medicine and dentistry get together.

Upon the suggestion of Dr. Sterling V. Mead, President of the American Dental Association, and with the hearty approval of the Medical

Society of the District of Columbia, Dr. Coursen B. Conklin, the Society's delegate to the American Medical Association, introduced the following resolution in the House of Delegates at its last meeting held in Chicago in December. The resolution read:

"WHEREAS the medical and dental professions have a common interest in the extension of health service;

WHEREAS there is need for closer coöperation between these professional bodies;

WHEREAS the President of the American Dental Association in recognition of this fact has appointed a committee of five dentists to coöperate with a similar number of representatives from the American Medical Association,

BE IT THEREFORE RESOLVED that this House of Delegates authorize the President to appoint a committee of five members of the American Medical Association to coöperate with a similar committee of the American Dental Association and that each state medical society be also urged to appoint a committee for the purpose of bringing about closer coöperation between physicians and dentists."

As previously reported in the MEDICAL ANNALS, this resolution was favorably received by the House which instructed that it be referred to the Board of Trustees with authority to act. Your Observer hopes the Board will act promptly, because it will be decidedly to the advantage of both professional groups to do so.

In the District of Columbia, the medical profession has worked closely with the dental organization, but there is still room for considerable improvement. It would be desirable, in your Observer's opinion, for the District of Columbia Dental Society and the Medical Society to resume joint meetings once a year. It would also be profitable if there were joint meetings of certain committees which consider problems of mutual interest.

Let us advance together to meet the serious problems of the day, and remember that we are not doctors and dentists, but doctors.

Group Hospitalization Approves

Another important step in the organization of MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA was taken early in the year. At a meeting of the Board of Trustees of Group Hospitalization, Inc., held on January 7, 1947, the Society's medical service plan was approved, and it was voted that GHI should administer its business affairs. Mr. Joseph H. Himes, GHI President, announced the Board's decision to the press. Since that time the Society has been officially informed by Mr. Himes of the Board's action.

It might be well to make it clear to members of the Society what GHI will actually do in administering MEDICAL SERVICE. GHI will solicit subscribers, collect their payments, pay participating doctors, and keep records of these transactions. The MSDC's Board of Trustees will control all medical aspects of the plan. Among other things it will determine the amount of service to be rendered subscribers and what physicians are to be paid, subject, of course, to the approval of participating physicians.

Although progress to date has been satisfactory, it will be several months before MSDC can be placed in operation. The next step will be for officials representing both GHI and MSDC to confer in regard to the conditions under which GHI will administer the SERVICE. Once the terms have been agreed upon, they must be submitted to each governing board for its action. Following their approval, forms will be sent to physicians with the request that those wishing to participate complete and return them promptly. At the same time GHI will be developing a system for handling MSDC's accounts. This will take considerable time, but once the task has been finished, the plan will go into operation promptly.

There may be some adjustments necessary in so far as the structure of the plan is concerned. Subscribers' dues and compensation for physicians' services will receive special attention. Changes will be made if possible in the organization stage.

It will be seen then that MSDC is making progress slowly but surely, which is the important thing.

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Medical Economics of Another Day[*]

As long ago as 1882, Dr. D. W. Cathell, Professor of Pathology at the College of Physicians and Surgeons of Baltimore, wrote a book entitled, "The Physician Himself and What He Should Add to His Scientific Requirements." The doctor did not confine himself entirely to economics, and much of the advice given was of a general nature, as the following quotations will reveal.

In the opening paragraph of the first chapter, Dr. Cathell writes:

> "There are gentlemen in the ranks of our profession who are perfectly acquainted with the scientific aspects of medicine, and can tell you what to do for almost every ailment that afflicts humanity, who, nevertheless, after earnest trial, have never achieved either reputation or practice, because they lack professional tact and business sagacity; and there is nothing more pitiful than to see a worthy physician deficient in these qualities, waiting year after year for a practice, and a consequent sphere of professional usefulness, that never comes."

Later in this chapter, the good doctor gets down to cases. He not only advises doctors with regard to their business affairs, but comes up with some revealing admonitions. Among these are the following: "Do not allow the ladies of the family to lounge about your office, read your books, answer the office bell, etc., lest it repel patients. Both messengers and patients prefer to meet either the doctor or his servant rather than ladies." "What shall I say of debauchery with harlots and association with concubines? Of drinking and gambling? My dear sir, if you have entered either of these roads, turn from it at once, for either will blast your career, will be fatal to every ambition." "Do not induce young men to study medicine, as there are already three doctors where one is required . . . but if you do so, charge them for the privilege not less than the usual fee of $100 per annum." "Do not let your office be a lounging place or a smoking room for horse-jockeys, dog-fanciers, gamesters, swaggerers, politicians, coxcombs, and others whose time hangs heavily on their hands."

As to the business side of the doctor's practice, Dr. Cathell says in part:

> "Have a copy of the fee table framed and hung in a semi-prominent position in your office, that you may refer patients to it whenever occasion requires. Also, have a small, neat sign, with 'Office Consultations from $1 to $10', posted in a semi-prominent place in your office. It will show your rule and tell your charges; it will also remind those who really forget to pay, of the fact, and will put less honest people in a dilemma. You can, when necessary, point to it and ask for your fee, and let them know you keep no books for office patients. Such a sign will save you many a misunderstanding and many a dollar. Of course, you may omit its cash enforcement towards persons with whom you have a regular account."

There is much more of this, but these quotations will serve to give you some idea what one doctor thought physicians in the early 1880's should know. Any physician who engaged today in financial practices which Dr. Cathell advocates would, to say the least, have some explaining to do to the Collector of Internal Revenue.

In 1905, nearly 23 years later, Dr. Joseph McDowell Matthews, President of the American Medical Association in the latter nineties, wrote a book on the subject, "How to Succeed in the Practice of Medicine." I will quote briefly from a chapter of his book entitled, "The Business Side of It":

> "It is writ that a man's first duty is to his family, and surely part of this duty is to support them, and in this age and generation one cannot live alone on air. There would be but one alternative left if he did not demand and receive pay for his services, and that would be that he 'sponge' and live off of his neighbors. Well, a long time ago this might have done, but in these days it won't work. Anyway, I always had a contempt for any able-bodied

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[*] From a talk given by Theodore Wiprud, Secretary of The Medical Society of the District of Columbia, at a meeting of St. Elizabeths Hospital Medical Society, October 22, 1946.

man, be he minister, doctor, or what not, that would 'sponge' off his neighbors. Yes, the medical profession will prove remunerative enough to support your family if you will demand pay for your services and see that you get it. If you do not do this, you are neither man or Christian; therefore, start out with the presumption that your services are worth what you ask for them, and be a good collector. In making this assessment, remember that a doctor's family should move in good society 'and wear good clothes.' You should consider that the wife is to be 'first lady' at the same time that you are playing the 'role' of first citizen of the country. I use the term 'first' advisedly, for I would have you start in your profession with no other idea than to be first in everything you undertake."

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New Leaders Emerge

Physicians who attend meetings of the AMA's House of Delegates for the first time come away with an entirely new conception of organized medicine. Your Observer cannot remember any physician making his initial visit to the House, even though in an unofficial capacity, who has not been impressed by what he had seen and heard. For here more than anywhere else the destiny of the medical profession is determined. If for no other reason, more physicians should make it a point to attend sessions of the House.

As Dr. Herbert P. Ramsey, Associate Editor of the MEDICAL ANNALS, has pointed out in several editorials devoted to the composition of the House, delegates are on the whole well along in years, their average age being about sixty years. However, there has recently been a slight downward trend, several states having chosen comparatively youthful, vigorous, and able leaders to represent them. Inevitably this group will have a great deal to do with the formation of the AMA's future policies. This is most encouraging to those who over a period of years have followed proceedings in the House. There was a time when delegates frequently voiced the opinion that medicine's affairs were none of the laymen's business. But that is no longer the prevailing view. Today the "isolationists" of medicine are on the way out and there is a more progressive spirit in evidence than at any time within your Observer's memory.

What the House does is of such vital importance to all physicians that your Observer would again urge members of the Medical Society to familiarize themselves with its proceedings. They are published in the *Journal of the American Medical Association* following each meeting of the House. Better than reading about what the House does is to attend its sessions. The next meeting of the House will be held at Atlantic City in June. All, except possibly executive sessions, are open to Fellows of the AMA.

This year for the first time the Medical Society will be represented by two delegates. Dr. Coursen B. Conklin, former Secretary, has been a delegate for several years. Well known to all members, he has wide experience in organization work and is highly regarded for his ability and integrity. Dr. Herbert P. Ramsey is a new delegate. He will be seated at the Atlantic City meeting for the first time. Much is expected of Dr. Ramsey for he has shown himself a capable leader in District medical and civic affairs. As both Dr. Conklin and Dr. Ramsey are well aware, there is no more important office in the Society than that of delegate to the AMA. Members can therefore be assured that they will represent the Society to the best of their abilities.

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Wanted: A Definition

It will be recalled that those who made the health and hospital survey for the Washington Metropolitan Health Council stressed the inadequacies of facilities for the care of the convalescent in the District of Columbia. "Social agencies seeking care for adult patients," the surveyors said, "have attempted to utilize facilities in the so-called nursing homes of the area. These homes follow the pattern of such units in other communities. There are exceptions but most of them are inadequate in both appointments and service with no suitable plan for medical supervision of the patients. They tend to prefer chronic rather than convalescent patients and, by virtue of being private money-making ventures, provide no resource for the patient who is unable to pay full charges. They are indeed a weak reed for the community to lean upon for its convalescent care, and, in our opinion, will never be of appreciable import in solving the convalescent problem."

No one knows how many beds there are available in these so-called nursing homes. Nor does anyone know the conditions, aside from those of a sanitary nature, which exist in them. The reason for this lies in the inadequacy of the District laws pertaining to institutions for the care of the sick. It appears that the District Code does provide for the establishment of institutions for sick "human beings and domestic animals," but there is no definition as to what constitutes a hospital, so that anyone may open a convalescent home subject only to such regulations as rooming and boarding houses must comply with. No one can therefore say definitely when a nursing home ceases to be a hospital and becomes a sanitarium, or when a sanitarium becomes a hospital, because the law does not specify. Your Observer was informed by a public health official that there would soon be a conference in the District at which revision of the present law with respect to the institutions for the care of the sick will be considered.

Certainly this is too dangerous a situation to be allowed to continue, and something should be done at once. To allow convalescent homes or nursing homes to operate without any responsibility for the proper care of the sick is to endanger the lives of the persons who are domiciled there.

Recognized hospitals in the District of Columbia, except Federal institutions, are under control of the District Health Officer. This should also be true of nursing homes and other institutions for the care of the sick. They should be inspected at frequent intervals and required to maintain high standards of medical service such as hospitals must do. Of necessity this would require an adequate staff of investigators and authority to enforce regulations.

Now, your Observer does not mean to suggest that there are not properly conducted nursing homes, for there are. In fact, there are several which do credit to those who operate them. However, they are costly for the person of ordinary means, and some way must be found to provide for individuals with small income. But first of all, health officials must be given some control over medical care in these institutions.

So what we most urgently need now is a legal definition of what constitutes a nursing home, a sanitarium, and a hospital in the District of Columbia.

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Who Are the Lobbyists?

Enactment of legislation by the last Congress regulating lobbyists has already evoked protests "because it was passed in utter disregard of the Constitution of the United States," and "because it is about as unnecessary a piece of legislation as was ever put on the statute books—which of course is saying a lot."

The new Lobbying Act provides that every person soliciting or receiving contributions for any organization or fund for lobbying purposes must not only register, but must keep a detailed account of such contributions, and the names and addresses of contributors of $500 or more. A record must also be kept of expenditures which are made for lobbying purposes on behalf of such organization, the name and address of recipients, and the dates on which the transactions took place. Receipts must be kept for expenditures in excess of $10 for at least two years.

Mr. Larston D. Farrar, writing in the *Washington News Digest* for January 1947, takes the position that the Lobbying Act "conflicts with the First Amendment to the Constitution," which reads: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech or of the press; or the right of the people peaceably to assemble *and to petition the government for a redress of grievances. . . .*"

Mr. Farrar also charges that the Act does not encourage more participation by the people in the Government but less. "For this reason," he says, "even if it were legal and Constitutional, it would still be harmful in a representative republican form of government such as ours was designed to be, and therefore is morally indefensible."

He points out that there is no definition of a lobbyist in the Act; that "every person who refers to another as a lobbyist in a derogatory sense, is in reality guilty at one time or another of lobbying himself." He is particularly wroth because "the biggest single group of lobbyists in Washington today" are exempt. They are the employees in the executive branch of the Government who are not required to register.

> "In net effect, what the lobbying act does is to make the men on one side of the national argument, now raging over free, private enterprise versus government socialism, register while letting the men who are on the other side of the argument go without registering, for the most part. Unless and until all lobbyists, including those in the government, are required to register, any person who feels injured by having to register under the present law will have a right to squeal."

Mr. Farrar is of the opinion that Congress enacted the law to quiet the demand for investigation of lobbying. At the time his article was written some 500 had returned forms stating that they were lobbyists. The first two to be returned, he says, surprised those who were under the impression that all lobbyists were lobbyists for utilities or some big or small business firm. First to register was the socialist, Benjamin Marsh, who represents "The Peoples' Lobby." The next was the Washington representative of the Women's Christian Temperance Union, which, according to Mr. Farrar, proves that "business does not have a monopoly on lobbying."

Mr. Farrar, your Observer believes, is too pessimistic with respect to the effect of the Lobbying Act. The fact that lobbyists will henceforth be known as such and that their activities will come under public scrutiny may prove beneficial to everyone concerned. It may bring to public attention the fact that there are many honest, intelligent lobbyists, thereby removing some of the unjustified odium which attaches to their vocation.

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Periodic Health Examinations

At a meeting of one of the Society's committees, held some weeks ago, a lively discussion ensued as to the value of the ordinary physical examination. One member was of the opinion that this type of examination, especially of adults, was of little value. Obvious defects, he admitted, were detected, but too often those of an obscure and more serious nature were overlooked. What was required in every physical examination, he said, was the use of every diagnostic aid available.

He said that the physician who makes the ordinary examination is not justified in telling the patient that he has nothing to worry about. Too often this is not true. He admitted that he had been criticized for employing all diagnostic refinements routinely, that this proved very costly to the patient. But costly or not, he said that when he had finished with the patient, the chance of anything being overlooked was slight.

Others present took the position that a careful clinical examination, especially if an adequate history were taken, served most adequately. Of course, certain laboratory procedures should be routinely employed—blood studies, urine analyses, and cardiograms in persons of more advanced years. There is no need, these physicians said, for such a complete and exhaustive examination as was advocated by their colleague.

Some stressed the importance of providing the patient with a clear, concise and understandable statement of findings.

Undoubtedly there is something to be said on both sides of this argument. The Medical Society, some years ago, endorsed a periodic health examination program. The question was raised as to the value of the type of examination then advocated by the Committee on Public Health. However, it was pointed out that these examinations were for screening purposes only. If there was any deviation from the normal, the individual was advised to have a more complete examination, including the use of such diagnostic aids as were indicated.

While this program had to be suspended during the War, the present Committee on Public Health recently gave consideration to its revival. However, due to the unusual demands still being made upon physicians in the District of Columbia, it was thought better to hold it in abeyance until an all-out effort could be made.

A number of physicians have continued to make periodic health examinations, using the form prepared for that purpose by the Committee. But there are still many physicians who are not "sold" on the idea. This, as much as anything else, has hindered medical societies here and elsewhere in their efforts to interest laymen in periodic examinations. Until more doctors are seriously interested, not much progress will be made in this important phase of preventive medicine.

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Eye Bank Encounters Obstacles

Such spectacular scientific achievements as the restoration of sight by corneal transplants are naturally of great public interest. So much has been written for lay consumption about the technical aspects of this operative procedure that it is not surprising some of it has led to confusion. As a matter of fact, erroneous impressions have already resulted in the failure of some persons to take advantage of this new scientific development where they might have benefited by it.

An example of this is the difficulty encountered by the "eye bank" sponsored by the Massachusetts Eye and Ear Infirmary. According to *The New England Journal of Medicine* for December 12, 1946, misconceptions in the minds of "certain lay persons" have impeded its progress. "In the first place," the *Journal* says, "there is the erroneous idea that *any* type of blindness can be cured by the substitution of a donor's eye. Secondly, it is rather widely believed that if an eye is not used within seventy-two hours it is completely wasted.

> "There is only one type of blindness that can be cured or improved in this manner, namely, that due to corneal opacities. Of the approximately 250,000 blind persons in this country, approximately 15,000 are blind because of corneal opacities. The latter stand a good chance of having their sight restored or improved by a corneal transplant from an eye removed within one hour of death and used within seventy-two hours. Although the group represents only a small percentage of those who are blind, the possibilities for beneficial results are impressive."
>
> "If the eye is not used within seventy-two hours, is it wasted? By no means. The eyes of mammals other than man are not entirely satisfactory for histologic, anatomic and physiologic studies, and yet such investigations must be carried out if the human race is to benefit. An intact human eye that could not be used for a corneal transplant might be ideal for certain studies, since it is presumably free from major defects and clearly has the properties common to other human eyes, except, of course, lack of circulation. Another important use for these eyes would be the training of ophthalmic residents in surgical procedures. This would be far superior to the present custom of employing animal eyes."

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Footnotes

Wisconsin has recently been the scene of a bitter struggle over the manner in which prepaid medicine shall be developed in that state. Antagonists are the State Medical Society of Wisconsin and the Medical Society of Milwaukee County. The basis for their differences is too involved to report here. What is of special interest is that the controversy has culminated in court proceedings being instituted by a state medical society against a component society. Naturally strong feelings have been aroused. It is not known at the time this is written whether it will be possible to bring about a settlement out of court. Efforts are being made to arrange for adjudication of the controversy by the AMA's Council on Medical Service. . . . Some clever headline writer has invented the name "Docvets" for District of Columbia Physician-Veterans of World War II. This organization has several worthwhile accomplishments to its credit. Recently, it took steps to prevent Government-financed medical graduates from becoming hospital residents in order to avoid immediate military service. A spokesman for the Docvets is quoted in the press as saying, "We believe these jobs should rightly go to competent physician veterans, and we hope most Washington hospitals will go along with us." Surgeon General Swanson of the Navy, he said, promised full coöperation, while Surgeon General Kirk of the Army explained that 3,000 medical school graduates whose tuition was paid by the Government now are available for army service, but the Army cannot use them just now, and therefore the deferments. . . . "Mortality from pneumonia in the District of Columbia is on the decline because of the wider use of penicillin and sulfa drugs," Dr. James G. Cumming, Director of the District Health Department's Bureau of Preventive Diseases, stated recently. In 1946, he said, pneumonia claimed the lives of 255 residents compared to 343 who died from the disease the previous year. Only 98 pneumonia cases have been reported to the Health Department for the month ending January 4, 1947, as compared with 158 the year previous. . . . An apt newspaper headline appeared in the *Washington Post* for Sunday, December 29, 1946. It read "Washington Began the Year In a Fog." Under this caption John Gerrity, the *Post's* feature writer, reviewed the events of the year during which "Washington's war-frazzled nerves danced and jangled to the strange and uncertain sounds of trumpets of peace." Further on, in Mr. Gerrity's article, your Observer's eye fell on this surprising statement: "To many, the news that three young men had been jailed the night before for the murder of Dr . Janvier W. Lindsay meant more than Hirohito's blunt admission that he was not God or that in London spokesmen for 51 nations, four fifths of the world's people, had sat down somberly to begin anew man's search for peace." Far from being dead, Dr. Lindsay is still a pretty lively fellow. Mr. Gerrity, it seems, was himself foggy when he thus grossly exaggerated the facts. . . . According to a London news dispatch, a Reuben Green was being fitted with a new denture but couldn't pay for it. He made the mistake of opening his mouth before he left the dentist's office, and Dr. Arthur Riser got the teeth. Green charged the dentist with assault. "He lunged at me, caught me on the mouth with his fist and took the choppers out," Green told the magistrate. Riser denied this. He said, "As Green started to leave without paying, I said, 'Let me see if they fit.' Green opened his mouth. I took the teeth."

T. W.

MEETINGS

Wednesday, March 5

BUSINESS MEETING

Wednesday, March 12

SYMPOSIUM ON RHEUMATOID ARTHRITIS

The Symposium will be sponsored by the *District of Columbia Rheumatism Society*. The following speakers from the Faulkner Arthritis Clinic, Presbyterian Hospital, New York, will participate: RALPH H. BOOTS, M.D., F.A.C.P., CHARLES A. RAGAN, M.D., AND HARRISON L. MCLAUGHLIN, M.D.

Wednesday, March 26

The Washington Gynecological Society will present the following program:

"Cancer of the Uterus with Respect to Diagnosis and Treatment," LEWIS C. SCHEFFEY, M.D., F.A.C.S., Professor of Gynecology, Jefferson Medical College of Philadelphia.

The Editors' Forum

THE NEED FOR IMPROVEMENT IN THE QUALITY OF MEDICAL CARE

Robert N. Nye, M.D.

Managing Editor, The New England Journal of Medicine

Editor's Note: *The New England Journal of Medicine* holds a unique place in American medicine. Although officially a publication of the Massachusetts and New Hampshire medical societies, it has a large national circulation and is considered by physicians everywhere one of the Nation's best medical journals.

One of the most serious omissions of national, state and county medical societies in the fight against compulsory health insurance appears to be their failure to recognize or to acknowledge that much of the medical care rendered in the United States is inferior. Many of the proponents of compulsory health insurance are well aware of this state of affairs and have made good use of it as propaganda, and Greer Williams, who acknowledges his willingness "to stick with the present system," has called attention to it in an article "Good Doctors Are Hard to Find," which appeared in the December 21 issue of the *Saturday Evening Post.* Williams writes, "Actually, when it [the AMA] speaks of America having the highest quality of medical care, the AMA is speaking of the top-grade doctors only."

Much has been said and written regarding the "health of the Nation" and the need for better medical care, but by and large, the health of any nation primarily depends more on its socioeconomic state—good wages, high standards of living, adequate housing and transportation facilities and a well educated public—than it does on medical care. On the other hand, sickness cannot be eliminated even in the healthiest of nations, and it is the direct or indirect responsibility of the medical profession to render, in the words of the Committee on the Costs of Medical Care, "adequate scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations of life." The cost and distribution of medical care are matters over which the physician has little direct control, as are the various adjuncts that are necessary for good medical care, such as well equipped hospitals, a sufficient number of nurses and progressive medical research. But, "adequate scientific medical service," provided that proper facilities are available, is the direct concern of the medical profession.

What are the prerequisites for the physician who renders high-grade medical care? In the first place, he must be a young man of more than average intellectual ability with a particular aptitude who has been granted his degree from an approved medical school. He must have received adequate hospital training, the duration of which depends on the type of medical practice that he chooses to follow. On beginning practice, he must become associated with a well equipped and well staffed hospital. These are the basic essentials, but they do not guarantee that this physician will give good medical care. He must keep himself professionally "fit" by constant reading, refresher courses and other methods of postgraduate education. Above all, he must fully realize his limitations, seeking the advice and assistance of more experienced or more highly trained men in cases that are puzzling or difficult. If all these requirements are met, the chances are excellent that this physician will render "adequate scientific medical service."

Unfortunately, however, this is an ideal that too frequently is not attained. In many states, a motley group of "doctors"—osteopaths, chiropractors, naturopaths and the like—are licensed by statute to care for the sick. One state still permits graduates of unapproved schools to take licensure examinations, and in a great many internship is not a necessary requirement for licensure. Too few hospitals are qualified for internships and residencies, and in too many the staff is so "closed" because of petty local politics that the recent medical graduate has no chance of becoming a member. Finally, the well trained young physician too often fails to appreciate that most of the medical practice of today is out of date in five years, and he too frequently assumes that no case is too obscure for him to diagnose or too difficult for him to treat medically or surgically.

All these matters are the collective or individual responsibility of physicians. State medical societies should promote legislation that places the care of the sick in the hands of those who are properly qualified, and they should sponsor various types of postgraduate medical education. The medical staffs of all except the smallest hospitals should strive to have their institutions qualify as "teaching hospitals," and all of them should welcome the recent medical graduate with open arms. And, most important of all, the physician must constantly continue his education and appreciate his limitations. When these things have been accomplished, but not until then, the medical profession may truly say that it dispenses the "highest quality of medical care."

WOMAN'S AUXILIARY NOTES

The first meeting of the Woman's Auxiliary to the Medical Society of the District of Columbia was held in October with Mrs. William P. Herbst, Jr., our new President, presiding. The other newly elected officers are as follows: Mrs. William J. B. Orr, First Vice President; Mrs. A. Barnes Hooe, Second Vice President; Mrs. Richard H. Todd, Recording Secretary; Mrs. Leo C. Varden, Corresponding Secretary; Mrs. A. Magruder MacDonald, Parliamentarian; and Mrs. Charles P. Howze, Historian.

At this meeting Mrs. Herbst announced the chairmen of the Standing Committees as follows: Social, Mrs. Leo Brison Norris; House, Mrs. George H. Crofton; Membership, Mrs. Fred R. Sanderson; Finance, Mrs. William Earl Clark; Publicity, Mrs. Harry Zehner; Program, Mrs. Tomas Cajigas; Ways and Means, Mrs. Robert E. Moran; *Hygeia*, Mrs. J. Chester Brady; Philanthropic, Mrs. Maurice A. Selinger. The Educational Committee, which had been inactive during the War, was reorganized with Mrs. Leon A. Martel as Chairman.

The members of the Auxiliary rendered substantial assistance to the administrative staff of the Medical Society in connection with its ANNUAL SCIENTIFIC ASSEMBLY. In November a tea was given for the wives of the new members of the Society. Guests of honor at the tea were the wives of those physicians who had returned from duty with the armed services.

The programs of the Auxiliary have been varied and interesting, as the following indicate: an off-the-record talk by Vice Admiral Forest P. Sherman, U.S.N.; a reading, "The Story of Christmas," by Alice Hutchinson Drake; and an address by Dr. W. W. Bauer, Director of the Bureau of Health Education of the AMA, on "The Obligations of the Medical Society and the Auxiliary."

In 1946 the Auxiliary donated a substantial amount toward the redecoration of the Society's auditorium. This year it expects to modernize and furnish a much needed powder room on the second floor adjoining the library. Financial contributions have been made directly to the following organizations: Community Chest, $150; District Tuberculosis Association, $10; and the Washington Heart Association, $50. Ten subscriptions to *Hygeia* were ordered for the reading rooms of the various branches of the Boys' Clubs and similar organizations.

The wife of any member of the Medical Society is invited to join the Auxiliary. The dues are $2 annually. The meetings are held on the second Wednesday of each month, at 11 a.m., October through May. The business meeting is followed by an interesting program and buffet luncheon. If your wife is interested in joining, please communicate with Mrs. Fred R. Sanderson, Chairman of the Membership Committee.

MRS. HARRY ZEHNER
Publicity Chairman

Washington Physicians of Yesterday

GEORGE WYTHE COOK, M.D., LL.D.

Dr. George Wythe Cook was born October 28, 1846, in Front Royal, Virginia. At the age of seventeen he enlisted in a cavalry regiment of the Confederate army, in which he served until he was severely wounded on May 28, 1864. He afterward studied medicine and graduated as M.D. from the University of Maryland in 1869. After nine years of active medical practice in his native neighborhood he removed to Washington, D. C., where he lived for the remainder of his life and attained an outstanding professional and civic position.

In addition to the practice of medicine, Dr. Cook's activities covered a wide and arduous range—hospital service, medical teaching, literary work, civic service, medical-society work, and especially Congressional legislation on medical matters. The catalogue of his committee and official activities in these various fields is much too long to be detailed in this sketch. He was President of the Medical Society of the District of Columbia in 1893 and 1917, and of the Medical Association of the District of Columbia, 1897–98, and he was active in the amalgamation of these two bodies, which was effected in 1911. With the exception of one year he was delegate to the American Medical Association from 1908 to 1919. He presided with dignity and credit over the centennial celebration of the organization of the Medical Society in 1917, having been chosen President for that year with this in view. Congressional incorporation of the Medical Society was an objective dear to Dr. Cook's heart; and as a one-man committee he persisted for years until his efforts were crowned with success in the passage of the Act of May 24, 1924, chartering the society.

(*Continued on page 118*)

MEDICAL CARE PROGRAM IN MARYLAND

Robert H. Riley, M.D., Dr.P.H.

Director, Maryland State Department of Health

Editor's Note: The following article* explains in some detail the state medical care program which operates in Maryland for the care of the medically indigent as well as the indigent patient. For those Washington physicians who are frequently called upon to treat patients in nearby Maryland counties, knowledge of the operation of this plan is desirable. The Maryland health authorities have requested the Society to urge its members who live in Maryland to coöperate in the Maryland plan whenever called upon to do so.

The Medical and Chirurgical Faculty (the State Medical Association of Maryland), aware of many deficiencies in the present status of medical care in Maryland and of the absence of an official warrant for any group in the state to evolve a coördinated program of medical care, proposed on August 23, 1939, in an open letter to the Chairman of the Maryland State Planning Commission, that a standing committee of the Commission be formed to survey the problems of medical care for the citizens of the state. It will be noted that the medical care program of Maryland was initiated by the medical profession and thus is bound to "enlist the coöperation and enthusiasm of the medical profession."

The suggested committee appointed by the State Planning Commission was composed of representatives of all agencies interested officially or on a voluntary basis, and held its first meeting in January, 1940. In the following years a field survey and other investigations were conducted to determine the availability of proper care. The objectives of the field survey were:

1. To study certain characteristics of the population
2. To describe existing medical care facilities including:
   a. Distribution of physicians, nurses, and dentists, and types of service rendered by each
   b. Functions of hospitals, health, and welfare departments
   c. Activities of other governmental, voluntary and private agencies
3. To estimate the number of indigent and medically needy and to analyze procedures followed by such individuals in securing medical care
4. To study the state health needs and give suggestions for securing more effective use of existing agencies, either by improving or extending their activities or by the organization of other services
5. To estimate the cost of such a program.

In April, 1944, the committee published its report recommending the establishment of a medical care program for the indigent and the medically needy of the counties. The report was presented to the Maryland Medical and Chirurgical Faculty at its annual meeting in April 1944, and was approved unanimously by that group and sent to Governor O'Conor with the request that he recommend the necessary legislation. A bill providing for this plan for medical care was passed by the State Legislature and became law on February 9, 1945, when signed by the Governor. Following substantially the committee's recommendation, the bill provided that the medical care program should be administered by the State Department of Health through a new Bureau of Medical Services and that an advisory Council on Medical Care be created, representing medical, dental, pharmaceutical, and nursing professions, hospitals, public health and welfare agencies. The law also provided that the new Bureau of Medical Services should perform duties in connection with the licensing of hospitals and the administration of chronic disease hospitals which are slated for postwar construction.

To support the medical care program for the first two years an apropriation of $200,000 per year was approved by the Legislature. This is much less than the estimated cost of an adequate program for all the counties of Maryland, but it is the general opinion that it will suffice for a beginning, especially since a general prosperity was prevailing at the time the bill was passed.

In order that state-wide policies might be flexible, allowing for adaptation to local needs in the various counties, the Council on Medical Care decided upon the creation of a County Advisory Committee on Medical Care for each county. These committees include three members named by the county medical society; one by the county or district dental society; one by the Maryland Pharmaceutical Association;

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* Reprinted from Am. J. Pub. Health, 1946, 36, 908.

the executive of the county welfare board; the chairman of the board of county commissioners or his delegate, and the county health officer, who serves as chairman. Individual counties may appoint supplementary members at their own discretion, but it was suggested that the total number of members should not exceed ten. The council recommended that health officers naming additional members choose them from among minority racial groups, the department of education, nurses, local hospitals, or public health lay organizations.

Before services are started in any county, the county committee must submit an accurate and completely defined program to the Bureau of Medical Services. Immediately after the plan's review and approval by the bureau, services may be inaugurated.

For the first few months eligibility for medical care services under this plan is confined to the recipients of public assistance from the county boards of public welfare, except in cases of emergency need, when the health officer may authorize care of medically indigent persons. The program will be widened to include individuals not on relief as soon as a satisfactory "measuring stick" can be developed by which to judge elibigility of this group. Final responsibility for certification of eligibility rests with the county health officer. In the future he or his designated agent will determine the eligibility of the medically indigent on the basis of certain medical and social factors not yet completely defined. Among the criteria will be the applicant's income and other resources, such as home-grown food, special expenses or current debts, family size, diagnosis of the illness, probable length and cost of the illness, status of the patient, whether chief wage earner or dependent, outlook for complete recovery or the likelihood of recurrence, probable effect on future earning capacity, eligibility for care under other programs, any insurance the patient may have, and, finally, whether or not the family would have to go into debt to pay the cost of needed care.

The comprehensiveness of the local program is to be determined by each county according to the most pressing needs of the area and the amount of money available. Services may include home and office care, surgery, obstetrical services, consultation, dental care, bedside nursing care, drugs, laboratory services, and clinics. Other types of services may be inaugurated with the approval of the Bureau of Medical Services.

Funds have been allocated to the counties in proportion to the number of persons receiving assistance from the county board of public welfare. In many counties several other agencies were already providing medical care. This program will not duplicate or replace any existing services, but it may supplement them or inaugurate new services.

To simplify and facilitate administration of the state-wide program, a uniform fee schedule has been adopted for all counties. Uniformity was thought to be especially important in cases where a physician lives near a county line and practises in more than one county. Rates on the fee schedule were determined in large part according to recommendations made by County Advisory Committees. Since few counties would provide all the services mentioned in the fee schedule at the beginning, each county was advised to reproduce the part applicable to its own program and distribute it among the physicians and dentists of the area.

A system whereby expenditures could be strictly limited to the funds available was necessary. Accordingly the funds on hand for each county have been set up in monthly allotments.

The fee schedule to which the Maryland counties adhere is given below:

Home Visits—day (8:00 a.m. to 8:00 p.m.)	$3.00
Home Visits—night (8:00 p.m. to 8:00 a.m.)	$4.00
Note: If physician treats more than one patient on a home visit, he shall recive the regular fee for the first patient, and $1.00 for each additional patient.	
Office Visits	$2.00
Note: No payment allowed for telephone calls.	
Hospital Visits—on medical care	$2.00
Travel—For home calls more than ten miles from the office of the physician, an additional payment of $1.00 will be made.	
Drugs—Fees for visits indicated above include payment for simple drugs customarily dispensed by the physician. If special drugs of a more expensive nature are indicated, a prescription may be written, and payment will be made direct to the pharmacist. If the physician finds it necessary to dispense drugs, the cost of which is greater than 50¢, he may enter the cost of the drug on his Medical Report in the space marked "Special Services," and additional payment to cover this will be made. Physicians are urged to avoid the use of proprietary remedies when drugs listed in the U. S. Pharmacopoeia or National Formulary can be used.	

Maternity Care—Including prenatal care, delivery, and postpartum care. Physician may refer patient to Health Department Clinic for prenatal and postpartum care if he so desires	$35.00
Note: The law makes no provision for payment to a midwife.	
Major Surgery—Including preoperative and postoperative care not to exceed	$50.00
Minor Surgery—Including preoperative and postoperative care (simple fractures, dilatation, curettage, etc.) not to exceed	$25.00
Assistant at Major Operation—Not to exceed	$10.00
Anesthetist—For general anesthetic—not to exceed	$10.00
Consultation—By local consultant	$5.00
By out-of-town specialist (Member of Specialty Board)	$10.00
Note: Mileage for out-of-town specialist will be allowed at 30¢ a mile one way, up to a maximum of $10.00.	
Dental Care—Single extractions—not to exceed	$2.00
Multiple extractions for same patient at same sitting—first tooth	$2.00
Each additional tooth	$1.00
Maximum payment for extractions for one patient	$10.00
Silver amalgam fillings, each $2.00 to	$3.00
Silicate, or other cement fillings	$2.00
Dental X-ray, each	$1.00
Maximum fee for dental X-ray on one patient	$5.00
Other office treatments	$2.00
Full dentures—to be made of vulcanite only:	
Upper or lower denture—not to exceed	$35.00
Upper and lower denture—not to exceed	$60.00
Repair of denture—not to exceed	$6.00
Home visits when essential—same basis as physicians	
Oral surgery—same basis as physicians	
Laboratory Service—In any program providing medical care, indicated laboratory services, including X-ray should be available. When there are existing free services they should be used. Physicians taking X-rays in their offices may be reimbursed at cost, not to exceed a maximum of $5.00 per patient. X-ray or other special laboratory services may be purchased from hospitals or private laboratories on a basis of minimum rates for indigent patients.	

Physicians and dentists are to submit to the county health officer a single report of services rendered to each patient. These reports are reviewed and approved by the county health officer, who sends them to the Bureau of Medical Services for payment.

If the health officer questions the accuracy or validity of any report received from a physician, pharmacist, or dentist of his county he may seek the advice of the County Advisory Committee on the matter. On the other hand, any physician or other person who has rendered medical services may present his case to the County Advisory Committee if dissatisfied with the payments received.

General policies governing the administration of the medical care program have been based upon recommendations made by the State Council on Medical Care. In determining these policies that group has given full weight and consideration to the opinions expressed by the County Advisory Committees on Medical Care and has also attempted to balance two more or less opposing principles. They recognized the dual importance of allowing individual counties the greatest possible freedom to adapt the program to their peculiar needs and, at the same time, of maintaining a reasonable degree of uniformity throughout the state in order to simplify administration, record keeping, and future evaluation of progress.

By October 25, 1945, the Chief of the Bureau of Medical Services reported that twenty-two counties had submitted final plans for their medical care programs. (As of January 1, 1946, all counties have accepted the plan.) Programs were actually in operation in a majority of these counties. Most of the final plans included requests for consultation service. Seven of them included specialty clinics, the types most frequently requested being ophthalmology, nose and throat, and psychiatry clinics. Nearly all of the remaining counties were working on their final plans by the end of August. Since the law inaugurating the medical care program did not go into effect until June 1, 1945, and funds were not available for its administration until July 1, this may be considered very satisfactory progress.

Maryland's medical care program is a result of the coöperative efforts of physicians, dentists, pharmacists, public health authorities, and welfare agencies, who are striving to bring adequate care within the reach of those who cannot afford to pay for needed services. Attempts are being made to provide better quality medical care to the indigent and medically needy residents of our counties by providing services of physicians and dentists, clinics in specialty fields, diagnostic laboratory services, consultation service, and bedside nursing care. Policies have been formulated with the full coöper-

(*Continued on page 118*)

News and Personals

Associated Medical Care Plans, Inc. which has been set up to coördinate the various state medical care programs of the American Medical Association, has announced the appointment of Frank E. Smith as Director, effective December 1, 1946. His office is located at 535 North Dearborn Street, Chicago 10, Illinois, telephone Superior 0880.

The Executive Office of the **American Board of Ophthalmology** announces that a directory of all diplomates to January 1, 1947, will be published soon. This directory will be arranged alphabetically and geographically. No biographical data will be included. Diplomates who have not already done so should notify the Board office at once, stating their name and address exactly as they wish them listed. The price of the directory will be $3.00 postpaid.

The 1947 examinations are scheduled as follows: Atlantic City, June 8–13; Philadelphia, June 13–16; Chicago, week of October 8.

All communications should be addressed to the American Board of Ophthalmology, Cape Cottage, Maine.

The activities of the **Psychiatric Personnel Placement Service,** jointly operated for the past year as an emergency placement program by the American Psychiatric Association and the National Committee for Mental Hygiene, have been taken over by the National Committee for Mental Hygiene, 1790 Broadway, New York 19, N. Y. Applications from physicians seeking placement in positions or in training in the field of psychiatry are still invited.

Surgeon General Thomas Parran of the U. S. Public Health Service announces that applications for fellowships in postgraduate public health training for physicians and engineers for the school year beginning in the fall of 1947 will be received at any time prior to May 1, 1947.

The fellowships are made possible by a grant of $228,400 from the National Foundation for Infantile Paralysis through funds contributed to its March of Dimes. They provide an academic year's graduate training of approximately nine months in an accredited school of public health or an acceptable school of sanitary engineering, to be followed by three months of field training, and are open to men and women, citizens of the United States, under 45 years of age. Physician applicants must have completed at least a year's internship.

CALENDAR OF MEETINGS

January 2	Executive Board, Woman's Auxiliary
January 6	Executive Board
	Washington Ophthalmological Society
January 7	Executive Committee, Washington Metropolitan Health Council
January 8	Woman's Auxiliary
January 9	Committee on Public Policy
	District Unit of American Diabetic Association
January 10	Committee on Postgraduate Education
January 13	Graduate Nurses' Association
January 14	District Dental Society
January 15	Scientific Meeting of Society
	Board of Trustees, Medical Service
January 16	Committee on Postgraduate Education
	Subcommittee on Mental Health
January 17	Subcommittee on Sanitation
January 20	Board of Censors
January 21	Compensation Insurance Committee
	Interprofessional Conference
January 22	Committee on Arrangements, Annual Scientific Assembly
	Subcommittee on Venereal Disease
January 24	Subcommittee on Maternal Welfare
January 25	Washington Psychoanalytic Society
January 27	Executive Board
	Grievance Committee
January 29	Scientific Meeting of Society
January 30	Undergraduate Nurses' Association

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The specific purpose of the fellowships is to aid in the recruitment of trained health officers, directors of special services, and engineers to help fill hundreds of vacancies existing in state and local health departments throughout the country. Further details may be secured by writing to the Surgeon General, USPHS, 19th and Constitution Ave., N.W., Washington 25, D. C., Attention Public Health Training.

Members of the Society may wish to pass on to interested individuals data regarding two coming examinations in the field of public health·

April 2, at the USPHS Dispensary, 4th and D Streets, S.W., examinations for appointment of nurses to the first three grades of the Regular Commissioned Corps of the USPHS.

April 9, USPHS Dispensary, for appointment to the Regular Corps of the USPHS. Seventy-five vacancies exist in the grades of Assistant and Senior Assistant Scientist. Commissions are available to scientists trained in bacteriology, mycology, parasitology, entomology, malacology, biology, chemistry, physiology, psychology, etc.

Application forms and additional information may be obtained by writing the Surgeon General, USPHS, Washington 25, D. C.

The Women's Medical Society of Washington has invited Dr. Catharine Macfarlane, Professor of Gynecology at the Woman's College of Pennsylvania, to be its guest speaker April 1, at 8 p.m., in the Medical Society's building. Her address will be on "Cancer Prevention." All members of the District Medical Society are cordially invited to attend this meeting.

This program will mark the beginning of National Cancer Control Month.

The District of Columbia Chapter of the American Physiotherapy Association would like to be of assistance whenever the services of qualified physical therapists are needed. Members of the Medical Society may obtain competent personnel by calling one of the following officers of the Chapter:

President: Miss Laura W. Field, 900 17th Street, N.W., telephone (office) District 5870, (residence) Michigan 1758.

Vice President: Mrs. Karl York, 118 East Greenway Blvd., Falls Church, Va., telephone Axminster 4487.

Secretary: Miss V. Jo Niebuhr, 9011 Mohawk Lane, Bethesda, Md., telephone Woodley 5800.

Treasurer: Miss Mary P. Billmeyer, 1406 Downing Street, N.E., telephone Michigan 6000, ext. 98.

Legislative Chairman: Miss Mia Donner, 1599 Colonial Terrace, Arlington, Va., telephone Glebe 1083.

Public Relations Chairman: Miss Margaret Knott, 4410 Livingston Road, S.E., telephone (office) Columbia 5500, (residence) Trinidad 7777.

The American College of Surgeons held its first Clinical Congress since 1941 in Cleveland, December 16–20. The following members of the Medical Society were among the 579 surgeons who were received into fellowship at the Convocation, the concluding event of the Congress: Drs. Clifford E. Bagley, Henry L. Darner, Milton L. Goldman and Allan E. King.

Major General Norman T. Kirk, Surgeon General of the Army, was among a group of six who received honorary fellowships. The others were surgeons from Belgium, Mexico and Venezuela.

The Medical Society, at its business session, November 13, authorized the establishment of a **retirement plan for employees.** At a meeting of the Executive Board, November 25, a policy was taken out with the New England Mutual Life Insurance Company through its local agent, William M. Werber. Employees who have served the Society for three years or more are eligible to participate. Appointed by the Board to act as trustees and to assume responsibility for the administration of the plan were Dr. William M. Ballinger, representing the Medical Society; Miss A. Louise Eckburg, representing the employees of the Society; and Mr. Frank R. Strunk, representing the insurance company.

On January 6 the Executive Board appointed the following members to serve on the Committee on Special events: Drs. Arnold McNitt, W. Ross Morris and W. Warren Sager.

Dr. Frederick O. Coe was nominated to succeed himself as Vice President of the Washington Academy of Sciences representing the Medical Society.

Mr. J. Richard Connelly was appointed Assistant Secretary of the Medical Society. Mr. Connelly has been Manager of the MEDICAL BUREAU for the past year, a position which he will continue.

The Board voted to reëstablish a Committee on Relations with the Legal Profession, and appointed the following physicians to serve: Dr. Frederick Fishback, Chairman; Drs. James A. Gannon and Don Johnson.

To further the practice of anesthesiology in the District of Columbia, a new **Section on Anesthesiology** has been proposed by interested physicians. The Executive Board, at its meeting on January 6, voted to recommend to the Medical Society that such a Section be added and that the By-laws of the Section, submitted to the Board, be ratified.

The following physicians, who held their first meeting at Doctors Hospital in June, 1946, will be considered the charter members of the new Section:

Drs. Seymour Alpert, John J. Andrina, William E. Bageant. Joseph B. Bogan, Weston Bruner, Jr., John L. Cardwell, Philip Diatz, Paul Elsberg, John E. Everett, Charles E, Fierst, John M. Gaines, Luther A. Gilliom, J. Phelps Hand, Joel Hoberman, Elizabeth Adams-Koppel, Howard Katzman, Philip Lowenthal, Edward B. Macon, John J. Mattare, Donald Stubbs, John A. Swartwout, Charles Suraci and Allen Widome.

Dr. Stubbs was appointed Temporary Chairman, and Dr. Fierst, Temporary Secretary.

At a subsequent meeting, December 17, the Section was formally organized and By-laws drawn up. The following officers were elected:

Dr. Bogan, *Chairman;* Dr. Jesse T. Mann, *Vice Chairman;* Dr. Fierst, *Secretary-Treasurer.*

The Section on Neurology invited members of the Section on Pediatrics to attend its meeting, February 6, which was held in the Society's library. The following program was presented: "Psychotherapy for Children," Dr. Dorothy Donley-Dowd, Child Care Center, Catholic University; "Subdural Haematomas in Infancy," Dr. Vasilios S. Lambros, Associate in Neurology, Children's Hospital.

The Section on Otolaryngology sponsored a dinner meeting, January 21, at the Metropolitan Club in honor of Dr. Dean M. Lierle, Professor of Otolaryngology at the State University of Iowa College of Medicine. Dr. Lierle gave an illustrated lecture on "Plastic Submucous Resection." About fifty physicians attended the meeting.

At the meeting of the **George Washington University Medical Society,** January 18, Dr. A. Wilbur Duryee, Associate Professor of Medicine, New York Postgraduate Medical School, spoke on "The Management of Arterial Occlusion."

The Washington Ophthalmological Society met in the Medical Society's building, January 6. The guest speaker, Dr. Charles E. Iliff, of the Wilmer Institute, Baltimore, delivered an address on "Beta Irradiation in Ophthalmology." Case presentations were made by Drs. M. Noel Stow, Ralph N. Greene, Jr., and Edward J. Cummings.

The Prince Georges County Medical Society, at its meeting, December 3, elected the following officers to serve during 1947:

Dr. Thomas A. Christensen, College Park, *President;* Dr. Louis Jimal, Cottage City, *Vice President;* Dr. Oscar Lavine, Mt. Rainier, *Secretary-Treasurer.*

The Clinico-Pathological Society met January 21 at the Kennedy-Warren with Dr. J. W. Lindsay as host. Two case reports were presented: "Brief Résumé of Two Vascular Cases of Some Interest," Dr. B. W. Leonard; "Ocular Torticollis," Dr. James N. Greear, Jr.

Colonel Harold W. Jones, Secretary-Treasurer, has opened a permanent office for the **Association of Honorary Consultants to the Army Medical Library** in study room 26, Library of Congress. All matters pertaining to the Association should be referred to him at that address. Mr. Herbert Perfett is in charge of the office. His telephone number is National 2722, Extension 459.

Colonel Joseph H. McNinch, M.C., has been designated **Commandant of the Army Medical Library** by the Surgeon General, succeeding Colonel Leon L. Gardner. During the War, Colonel McNinch served on the staff of Major General Paul Hawley, Chief Surgeon of the European Theater of Operations. Upon his return he assumed the position of Chief of the Historical Division, SGO, where he is compiling the History of the Medical Department in World War II.

The Instructive Visiting Nurse Society reëlected its officers at a meeting of the Board of Directors, January 14. They are as follows: Miss Elsa M. Peterson, President; Mrs. J. William Fulbright, Secretary; Corcoran Thom, Jr., Treasurer.

Miss Gertrude Bowling, Director of IVNS, reported that the organization had suffered a net cut of approximately $10,000 in its 1947 budget, which she attributed to the failure of the Community Chest campaign to attain its goal. She said the agency's budget normally amounts to more than $200,000.

Surgeon General of the Army Kirk formally opened the new **Aural Rehabilitation Center** at the Forest Glen, Md., section of Walter Reed Hospital, January 19. The new center will consolidate all the Army's facilities for providing deaf servicemen with hearing aids, replacing three Army aural rehabilitation centers established during the War at Butler, Pa., Chickasha, Okla., and Santa Barbara, Calif. Latest developments in aural training installed at the Center include courses in lip-reading and speech correction. The Center will have its own laboratory to fit hearing aids by means of individual ear molds.

Members of the Society's Section on Otolaryngology were invited to attend the installation services as guests of General Kirk.

Colonel Raymond O. Dart has succeeded **Colonel James E. Ash** as **Director of the Army Institute of Pathology.** Colonel Dart has practiced pathology for more than 25 years, and was associated with the Army Medical Museum and the Army Institute of Pathology for approximately eight years prior to the War. For part of that time he served as Curator.

Colonel Ash has been Director of the Institute for the past nine years. He is now the Scientific Director of the American Registry of Pathology, a major department of the Institute which is sponsored by the Division of Medical Sciences of the National Research Council.

Major General Norman T. Kirk, Surgeon General of the Army, was recently awarded the Legion of Merit for his services as Commanding Officer of Percy Jones General Hospital during 1942 and 1943. The citation read: "Major General Norman T. Kirk rendered exceptionally meritorious service as Commanding Officer, Percy Jones General Hospital, from June 15, 1942, to April 13, 1943. His conspicuous performance as an organizer, administrator, and professional surgeon culminated in the establishment of the country's largest Army Hospital Center which has been unexcelled for eminent achievement in military medicine." Presentation was made in the Pentagon by Major General Henry S. Aurand; the citation was read by Colonel H. W. Doan.

Captain Elmer Klein, M.C., U.S.N.R., was commended recently for "exceptional meritorious conduct in the performance of outstanding service in the line of his profession to the Government of the United States as Chief of the Neuropsychiatric Department of U. S. Naval Base Hospital No. 18." Captain Klein arrived in Guam with the Fourth echelon in August 1944 during the early period of reconstruction of that island and rendered "valuable assistance in organizing, planning and the training of personnel of the neuropsychiatric department of the hospital. He was placed in charge of this department from the time the hospital was commissioned in November 1944 until October 1945.

"During this period Commander Klein displayed exceptional ability and worked tirelessly in handling the problems incident to the organization and maintenance of his department. His devotion to duty contributed materially to the effective administration of the hospital and the high professional care rendered to the neuropsychiatric patients.

"His sound judgment, the efficient handling of the administration of his department and his unwavering devotion to duty were in keeping with the highest traditions of the United States Naval Reserve."

Dr. Charles Stanley White, Chairman of the Medical Alumni Committee for the **George Washington University Hospital Equipment Fund,** was presented a check for $800 by the Lions Club of Washington at a luncheon at the Hotel Mayflower, January 15. The contribution was made in memory of the late Dr. Guy W. Leadbetter, who, at the time of his death, November 11, 1945, was Clinical Professor of Surgery of the School of Medicine.

The gift will be used to equip an orthopedic cast room in the outpatient department of the new

Hospital. The presentation was made by Mr. Harold E. Warner, Chairman of the Club's Committee on Welfare Activities. In accepting the gift, Dr. White paid tribute to Dr. Leadbetter's work in orthopedics and to his record as a member of the University faculty since 1928.

Dr. C. Willard Camalier has accepted the chairmanship of the Dental Alumni Committee for the Equipment Fund drive. According to Dr. White, the quota for medical, dental and pharmaceutical alumni in the District area is $110,000.

Dr. Norman Q. Brill was among the consultants to the Secretary of War who were called together to review current neuropsychiatric practices and to consider long-range plans in the field of psychiatry. Dr. William C. Menninger, formerly Chief of the Neuropsychiatry Consultants Division during the War with the rank of Brigadier General, presided at the meetings, which were held January 20 and 21 in the office of the Surgeon General of the Army.

Dr. Edward J. Stieglitz will be the speaker, March 3, at the meeting of the **Silver Spring Academy of Medicine.** He will talk on "The Significance of Geriatrics." His paper will be discussed by Dr. Wallace M. Yater.

Dr. Joseph S. Lawrence and Dr. Herman E. Hilleboe were among the speakers at the 20th Annual Meeting of the National Conference on Medical Service, in Chicago, February 9. Dr. Lawrence discussed health legislation which will be considered by the Eightieth Congress. Dr. Hilleboe discussed the Federal Hospital Survey and Construction Act.

Dr. Mary Holmes, retired Washington physician and a member of the Medical Society, was one of two outstanding alumni of Eastern High School who were honored at the annual dinner of the Alumni Association, December 18. Dr. Holmes was a member of Eastern's first graduating class in 1893. About 400 alumni attended the dinner.

Dr. Charles R. Drew has been appointed Medical Director and **Mr. Charles E. Burbridge,** Superintendent, of **Freedmen's Hospital,** filling the vacancy caused by the recent resignation of Dr. James L. Hall, who resigned as Superintendent to resume private practice of medicine in Chicago.

The Reverend Dr. Thomas V. Moore, O.S.B., head of the Department of Psychology and Psychiatry at Catholic University and head of the University's Child Center, was honored at a testimonial banquet, January 13, at the Shoreham Hotel. Dr. Moore, who left for Spain, January 22, will give a course of lectures at the University of Madrid upon invitation of the Spanish Ministry of Education. He plans to spend several months in Madrid.

Dr. Worth B. Daniels presented a paper on "Meningococcic Infection" at the monthly staff meeting of Mount Alto Hospital, January 6. Dr. Daniels, a graduate of Johns Hopkins University, is Clinical Professor of Medicine at Georgetown University. During the War he served as Consultant to the Eighth Army, and upon returning to this country, was Chief of Medicine at Walter Reed General Hospital.

Drs. Wallace M. Yater, Leonard T. Peterson and William S. McCune have been added to the list of Society members who are participating as speakers in the Professional Staff Proceedings of Walter Reed Hospital.

Dr. Alfred J. Suraci and Dr. Louis Milobsky, dentist, presented a paper on "Maxillo-Facial and Reconstructive Surgery" before the District Dental Society, January 14.

The Dental Society announces that the name of the Five State Postgraduate Clinic, which is held annually, has been changed to **The District of Columbia Postgraduate Clinic** and will be held March 10–13 at the Statler Hotel.

Dr. Dean M. Hayes was recently appointed Civilian Consultant in Physical Medicine to the Surgeon General of the U. S. Army for Walter Reed General Hospital and the Second Army.

Dr. James A. Gannon addressed the Junior Board of Trade at the Annapolis Hotel, January 16, on "Do Drugs Really Cure?"

Station WOL advises the Society that Dr. Gannon's "Your Health" broadcasts on Sunday afternoon have achieved the second highest Hooper rating in the city; i.e., at 3:15 p.m. there is only one other station that has more listeners.

Dr. Winfred Overholser addressed Washington alumnae of Ward Belmont College, January 14, at the Mayflower Hotel on "Civic Problems of Psychiatry."

Dr. Joseph W. Stein was elected to Associate membership in the International College of Surgeons during its recent meeting in Detroit, October 21–23, 1946.

Dr. John R. Cavanagh, Associate Professor of Clinical Medicine at Georgetown University School of Medicine, served as medical adviser for a course on "Marriage Preparation" sponsored by the Young Christian Workers during January and February at the National Catholic School of Social Service. Dr. Cavanagh also delivered two lectures during the course: February 12, "Male and Female Anatomy and Physiology"; February 19, "The Marriage Relationship."

Dr. Eugene deSavitsch was decorated with the Order of Leopold the Second, rank of Officier, on January 4, in recognition of his services to Belgium. The honor was conferred upon him by Baron Robert Silvercruys, the Belgian Ambassador, in behalf of H. R. H. Prince Charles, Regent of Belgium.

Dr. Joseph S. Wall was one of six Central High School alumni honored at the 38th annual reunion of the school's alumni, January 16.

Dr. Richard H. Todd addressed a meeting of the Woman's Club of Lyon Village, January 8. He discussed new developments in medicine, with emphasis on allergies.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, January 6, 1947, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

Louis K. Alpert, 1801 K Street, N.W.
Thomas M. Anderson, Veterans Administration
Frank S. Bacon, 1150 Connecticut Avenue, N.W.
Sidney Berman, 1402 Jefferson Street, Michigan Hills Park, Md.
Brian B. Blades, 1335 H Street, N.W.
John F. Brennan, Jr., 1201 Monroe Street, N.E.
Philip Burka, 1834 Connecticut Avenue, N.W.
Rex E. Buxton, 5202 Western Avenue, Chevy Chase, Md.
John J. Calarco, 3801 Suitland Road, S.E.
George J. Cardany, 3547 Chesapeake Street, N.W.
Joseph M. Cocimano, 2863 Denver Street, S.E.
Maynard I. Cohen, 2440–16th Street, N.W.
William H. Devlin, 3500–14th Street, N.W.
Elbert W. Dodd, Jr., 1103–16th Street, N.W.
Reaumur S. Donnally, 6450 Brooks Lane, N.W.
Joseph A. Dugan, 4312 South Dakota Avenue, N.E.
Henry D. Ecker, 3309 Highland Place, N.W.
John A. Farrell, 1201 Allison Street, N.W.
Julius Fogel, 1726 M Street, N.W.
William D. Foote, 1800 Eye Street, N.W.
Maurice H. Friedman, 2040 Belmont Road, N.W.
Landon G. Gant, 1726 Eye Street, N.W.
Jules Gilbert, 1418 Trinidad Avenue, N.E.
Leonard Gilman, 1713 Luzerne Avenue, Silver Spring, Md.
David S. Gordon, 3003 Naylor Road, S.E.
Everett J. Gordon, 2025 Eye Street, N.W.
Isaac S. Grisoff, 1736 Columbia Road, N.W.
William H. Hanna, 1801 K Street, N.W.
Dean H. Harding, 113 Carroll Street, N. W.
John H. Hill, 1150 Connecticut Avenue, N. W.
Thomas A. N. Hindman, 2025 Eye Street, N.W.
Hugh W. Irey, 1833 Monroe Street, N.E.
Robert T. Jackson, 235 Orange Street, S.E.
Daniel S. Jaffe, 900–17th Street, N.W.
Robert E. James, 1406 North Veitch Street, Arlington, Va.
Joseph T. Jana, Jr., Garfield Hospital
Harold J. Jeghers, Georgetown Hospital
Charles W. Jones, 1629 Columbia Road, N.W.
Herman Kabat, 2633–16th Street, N.W.
Paul J. Kelley, 1626 Minnesota Avenue, S.E.
Calvin T. Klopp, Warfield Memorial Clinic.
Elizabeth Adams-Koppel, 437 Cedar Street, N.W.
Harold J. Kurtz, 601–19th Street, N.W.
Justin E. Lacy, 2650 Wisconsin Avenue, N.W.
John W. Latimer, Jr., 1835 Eye Street, N.W.
Mark H. Lepper, 2111 Bancroft Place, N.W.
A. Burton Mincosky, 1633 Connecticut Avenue, N.W.
Lloyd H. Mousel, 5401 Allan Road, N.W.
Leo H. Mugmon, 2946–2nd Street, S.E.
James P. Murphy, 2014 R Street, N.W.
John C. Murphy, 1801 Eye Street, N.W.
David M. Nolan, 2811 Pennsylvania Avenue, S.E.
Stanley L. Olinick, 1103 Trenton Place, S.E.
Edward A. Palank, 3503 Minnesota Avenue, S.E.
Norman Paul, 3951 Langley Court, N.W.
Andrew G. Prandoni, 2025 Eye Street, N.W.

John C. Ransmeier, 2310 Connecticut Avenue, N.W.
Isadore Rod, 4007 Connecticut Avenue, N.W.
Robert L. Roy, 1205 Farragut Street, N.W.
William T. Saccardi, 1801 K Street, N.W.
Aaron G. Saidman, 1835 Eye Street, N.W.
Julius Schreiber, 1029–17th Street, N.W.
John N. Shadid, 3516 B Street, S.E.
Morris Silverman, 2025 Eye Street, N.W.
Arthur I. Sims, Gallinger Hospital
Louis C. Skinner, Jr., 2100 Connecticut Avenue, N.W.
Max H. Skolnick, 900–17th Street, N. W.
F. Daniel Suttenfield, 1302–18th Street, N.W.
Celia W. Tabor, 3130 Wisconsin Avenue, N.W.
Oswald V. Todd, St. Elizabeths Hospital
Charles P. Waite, 4700 Connecticut Avenue, N.W.
Donald Walters, 1549 Ft. Davis Street, S.E.
Wendall M. Willett, 1726 M Street , N.W.
Prentiss Willson, Jr., 900–17th Street, N.W.
Edward C. Wilson, Jr., 1801 Eye Street, N.W.
Irwin I. Yager, 726 Gallatin Street, N.W.

Associate Members

Merrill M. Cross, 8512 Georgia Avenue, Silver Spring, Md.
Julius Kauffman, 5423 Annapolis Road, Bladensburg, Md.
Marion R. King, 2480–16th Street, N.W.
Morris I. Michael, 1427 Good Hope Road, S.E.
Eugene A. Patouillet, 6201–20th Avenue, Hyattsville, Md.
Mark L. Stone, 1650 Harvard Street, N.W.
Edwin R. Weinerman, 2702 Allison Street, Mt. Rainier, Md.
Blanche B. Wilcox, Ph.D., 1421–29th Street, N.W.
Frank A. Zack, 8248 Georgia Avenue, Silver Spring, Md.

The following applicants for membership will be voted on at the meeting of the Executive Board, February 24, 1947.

For Active Membership

Agnes Conrad, Johns Hopkins University—1925
Ambrose H. Cook, Georgetown University—1927
Edward H. Cushing, Harvard Medical School—1923
Joseph M. Daly, Georgetown University—1939
Howard A. Donald, George Washington University—1939
Jerome D. Frank, Harvard Medical School—1939
Joseph M. Friedman, George Washington University—1939
George D. Gartland, Temple University—1939
Thorval L. Hickman, George Washington University—1941
Herbert E. Martyn, Jr., George Washington University—1943
Lawrence A. Pyle, Jr., Duke University—1939
Leonard B. Rose, Georgetown University—1943
Frederick H. Scharles, Washington University—1929

For Associate Membership

Bruce T. Benjamin, College of Medical Evangelists—1939
Anna C. G. Knop, University of Hamburg, Berlin—1937
Rowland F. Wilkinson, College of Medical Evangelists—1943

The following applicants for membership will be voted on at the meeting of the Executive Board, March 31, 1947.

For Active Membership

Albert A. Ackerman, Washington University, St. Louis—1940
Lester J. Dugan, Georgetown University—1934
Lester I. Fox, University of Maryland—1938
John P. Gallagher, Long Island College of Medicine—1938
Frederick B. Hartsock, George Washington University—1945
Julian G. Kirchick, University of Maryland—1940
Spencer V. Meade, George Washington University—1930
Erwin Pésé, Friedrich Wilhelm University of Breslau—1924
Robert D. Ralph, Queens University, Canada—1932
Hugo V. Rizzoli, Johns Hopkins University—1940
David H. Rosenfeld, University of Maryland—1933
Alexander Tish, New York University—1922
Raymond J. Winfield, George Washington University—1943
Thomas C. Worth, Harvard University—1936

For Associate Membership

Frank G. Leslie, University of Pittsburgh—1936
George N. Schultz, Georgetown University—1944

Recent changes in membership status:

Active to Associate

Edward C. Durkin
E. Parker Luongo
Robert Oden

Resigned

Active

Mortimer Ostow
Mario Scandiffio

Associate

Joseph M. Moore
Arturo B. Rotor

Twelve New Life Members

Chapter II, Article IV, of the Constitution of the Society, reads as follows:

> Life members shall be active members who have been active members for a total of forty years. They shall have all of the privileges of active membership and shall be exempt from paying dues and assessments.

Our honor roll now numbers 84. The congratulations of the Society are extended to:

Seniority Number		*Date of Membership*
398	Roy D. Adams	April 4, 1906
399	Seneca Bray Bain	April 4, 1906
400	Homer G. Fuller	April 4, 1906
402	George Tully Vaughan	April 4, 1906
407	Frederick Yates	April 10, 1906
409	Edward Y. Davidson	April 27, 1906
411	Harry H. Kerr	May 3, 1906
413	William B. Mason	October 3, 1906
415	Charles W. Hyde	October 3, 1906
418	William Robert Perkins	October 9, 1906
421	Aloysius W. Valentine	October, 1906
423	Edward Warren Burch	October, 1906

who have for forty years been on the roster, meeting all dues and assessments and lending their support to the Society by frequent attendance. Their status is now elevated to Life Membership.

CORRESPONDENCE

Washington 25, D. C., December 31, 1946

Mr. Theodore Wiprud
Secretary, The Medical Society of the District of Columbia
1718 M Street, N.W.
Washington 6, D. C.

Dear Mr. Wiprud:

I would appreciate greatly if the following information would be disseminated to the members of the District of Columbia Medical Society, inasmuch as many members are referring veterans direct to Mt. Alto Hospital for outpatient treatment.

The following is an excerpt from the *Evening Star* dated December 18, 1946, which is self-explanatory.

"Washington area veterans in need of hospitalization or outpatient medical treatment were reminded today that all such applications should now be made through the new Veterans Administration medical clinic in VA's Washington Regional Office at 1825 H Street, N.W.

"Although notices that VA's clinic has been transferred from Mt. Alto VA Hospital to the new office were published recently, an average of 75 veterans daily still are applying for treatment and hospitalization at the hospital.

"Outpatient treatment is limited by law to veterans with service-connected disabilities, the VA emphasized.

"Mt. Alto's staff is no longer set up to extend outpatient service or to make examinations for hospitalization. With the transfer of the clinical units that had been at Mt. Alto to 1825 H Street went the responsibility of authorizing outpatient treatment and hospitalization for veterans in the Washington area.

"Admitting facilities at Mt. Alto now are limited to prearranged admittances through the Regional Office and to night, Sunday and holiday emergency duty when the downtown clinic is closed.

"The new VA clinic occupies the third and fourth floors at 1825 H Street, N.W., and applicants for outpatient treatment or hospitalization should report to the receptionist in Room 418. Telephone inquiries should be made through Executive 6500.

"Emergency outpatient service is available at 1825 H Street, Monday through Friday, from 4:45 p.m. to 9:00 p.m., and on Saturdays from 9:00 a.m. to 5:00 p.m. On week nights and on Sundays and holidays application for treatment or hospitalization in emergencies only may be made at Mt. Alto Hospital, and telephone calls at those times should be made through Woodley 5800."

Very truly yours,
Spencer V. Meade, M.D.
Chief Medical Officer,
Regional Office, Veterans Administration

HOSPITAL STAFF MEETINGS

Hospital	*Day of Month*	*Time*
Alexandria	1st Wednesday	9:00 p.m.
Arlington (Meetings held at County Health Dept., 1800 N. Edison St.)	1st Thursday	8:00 p.m.
Casualty	1st Thursday	1:15 p.m.
Children's	1st Monday	1:00 p.m.
Columbia	2nd Friday	8:30 p.m.
Doctors	1st Monday	8:30 p.m.
Emergency	4th Tuesday	12:00 m.
Episcopal Eye, Ear and Throat	1st Friday	8:15 p.m.
Freedmen's	Last Friday	11:00 a.m.
Gallinger	2nd Thursday	11:30 a.m.
Garfield	1st Wednesday*	12:00 m.
George Washington (Meetings held at 1335 H St., Hall A)	1st Monday after 1st Tuesday	12:15 p.m.
Georgetown (Meetings held at 36th St. and Prospect Ave.)	2nd Monday	12:00 m.
Glenn Dale	Every Thursday	1:00 p.m.
Homeopathic	3rd Tuesday	1:00 p.m.
Mount Alto	1st Monday	8:15 p.m.
Naval	Every Friday	1:30 p.m.
Prince Georges	3rd Tuesday	8:30 p.m.
	Last Sunday	11:00 a.m.
Providence	2nd Tuesday	9:00 p.m.
	3rd Tuesday	11:30 a.m.
Saint Elizabeths (Meetings held at Blackburn Laboratory)	Every Tuesday	11:30 a.m.
Sibley	2nd Tuesday	11:00 a.m.
Suburban	2nd Tuesday	8:30 p.m.
Walter Reed	Every Saturday	11:00 a.m.
Washington Sanitarium	3rd Monday	8:00 p.m.

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* February, May, October and December.

Note: Except where indicated the meetings are held at the hospital.

CHARLES KNELLER KOONES, M.D.

(1866–1947)

Dr. Charles K. Koones, a Life Member of The Medical Society of the District of Columbia, died January 14, 1947, at his home, 3223 Garfield Street, N. W.

Dr. Koones had practiced medicine in Washington for more than sixty years before his retirement three years ago. Born in Richmond, Virginia, October 24, 1866, he came to Washington when a young boy. He graduated in medicine from Columbian University (now George Washington University) in 1887 and interned at Washington Asylum, Emergency and Providence Hospitals. He was also resident physician at Washington Asylum and Providence Hospital.

Elected to membership in the District Medical Society in 1890, he became a Life Member in 1931. He was a Fellow of the American Medical Association and a member of the Knights of Columbus.

Surviving are his wife, Mrs. Eleanora Blanford Koones; a daughter, Mrs. Elizabeth Henius; a son, Charles C. Koones; and a brother, Samuel Shively Koones, all of Washington.

Pediatrics—Ross and Wall

(*Continued from page 75*)

48. Gellis, S. S., McGuinness, A. C., and Peters, M.: Am. J. M. Sc., 1945, **210**, 661.
49. Bahlke, A. M., and Perkins, J. E.: J. A. M. A., 1945, **129**, 1146.
50. Enders, J. F.: J. Pediat., 1946, **29**, 129.
51. Levens, J. H., and Enders, J. F.: Science, 1945, **102**, 117.
52. Habel, K.: Pub. Health Rep., 1945, **60**, 201.
53. Enders, J. F., Cohen, S., and Kane, L. W.: J. Exper. Med., 1945, **81**, 119.
54. Members of the Commission on Influenza, Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army, Preventive Medicine Service, Office of the Surgeon General, United States Army: J. A. M. A., 1944, **124**, 982.
55. Grant, H. B.: J. Pediat., 1946, **29**, 485.

Maryland Program—Riley

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ation of all the groups concerned, and a continued unified effort is essential to the success of this undertaking.

The program is a new venture in public health and one that may be accompanied by errors. It is believed, however, that vigilance to detect these mistakes and willingness to correct them will help to insure its success. Above all, needs of groups intended to benefit from the medical services must be kept in the foreground, for the entire medical care program has been established for the sole purpose of serving these sections of our population.

Washington Physicians of Yesterday—Cook

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His associates entertained the highest affection and esteem for Dr. Cook, and repeatedly tendered tributes and testimonials in his honor. In personal character, gentle and kindly in manner, retiring and modest, was he; and yet when stirred to action by emotion or righteous indignation he was a man of forcefulness and spirit. He was a thorough and courteous gentleman by birth and breeding, affable, high-minded and cultured, of impeccable integrity of character.

In 1877 Dr. Cook married Rebecca Lloyd. She died February 19, 1928, and Dr. Cook on the 26th of the following December, 1928. Their only child, Richard Lloyd Cook, born in 1878, graduated M.D. from the University of Virginia in 1904 and served with distinction in the Medical Corps of the United States Army during World War I and later as hospital director in the Veterans Administration. He is now retired and living in Washington, D. C.

The family tradition is also carried on by Dr. Henry C. Macatee, a nephew of Dr. Cook, who with similar ability, energy, and credit has carried on helpful service to the profession like that rendered by his uncle.

John B. Nichols, M.D.

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NON-DYSENTERIC AMEBIASIS: GENERAL CONSIDERATIONS AND POSSIBLE RELATIONSHIP TO RHEUMATOID ARTHRITIS

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Washington

My interest in the problem of non-dysenteric amebiasis was first stimulated in 1922 by Colonel Charles F. Craig who was then on duty at the Walter Reed Hospital. Prior to then, I had thought of amebiasis only in terms of amebic dysentery. Colonel Craig at this period was active in calling the attention of the profession to the significance of the carrier state, and some of my early cases were diagnosed in his laboratory. I was impressed with the importance of the problem and with the apparent fact that too little attention was being paid it; these points of view were forced upon me by very favorable therapeutic results observed in certain chronic colonic disorders, which followed eradication of the ameba.

The term amebiasis really means the invasion of any tissue of man by Endamoeba histolytica and includes all degrees of pathologic change, whether microscopic or macroscopic. The usual involvement is of the intestine, but various other tissue may be involved, especially the liver. Amebic dysentery is only a severe symptom-complex which may or may not be seen in a case of amebiasis.

The older concept that amebiasis was largely confined to tropical and subtropical areas has long been disproved It occurs anywhere, although it is true that it is most prevalent in tropical areas, probably secondary to bad sanitary conditions existing in most areas of the tropical part of the world. The disease occurs fairly commonly in individuals who have always lived in temperate or even cold regions.

The life cycle of Endamoeba histolytica follows a vegetative, a precystic, and a cystic stage. Occasionally one hears the statement that the findings of cysts in the feces mean little. That is, of course, an inaccurate point of view, because the cysts come only from vegetative forms. Where cysts are found, vegetative forms must of necessity exist. The amebae enter the body by being swallowed in either contaminated food or drink. They pass unharmed through the stomach and tend to grow in the right colon and terminal ileum. From this area, as they pass out, encystment tends to occur. In diarrheal states, the vegetative forms are swept out as such and before encystment takes place.

There is some conflict of judgment as to whether the Endamoeba histolytica may exist in the intestinal canal as a parasite feeding on the intestinal contents, or whether it is always a tissue parasite. Judging from my experience, the organism must always be regarded as a tissue parasite. If so, every infected individual does in all likelihood have constant invasion of the intestinal mucosa, producing lesions of various size from microscopic lesions to gross ulcerations. I believe this to be true even though a certain degree of immunity may apparently occur and be maintained.

As above indicated, although it has been generally accepted for years that Endamoeba histolytica is the cause of dysenteric states, it has been only within recent years that it has been recognized as the cause of less striking illnesses. True amebic dysentery arises only in those cases of amebiasis in which extensive ulceration of the infected intestine has arisen.

It has been well established by numerous investigators that in the carrier state of amebiasis, in the absence of dysentery or looseness and even in states of constipation, indolent ulcers and microscopic lesions exist. These conclusions have been reached by autopsy work in cases of carriers who died of other diseases.

The disease may be transmitted by food handlers who have the carrier state, as well as by the ingestion of food or liquid contaminated in other ways. It is likely that in areas of good sanitation, food handlers may be the most frequent source of transmission. Faulty plumbing devices have caused epidemics, as, for instance, the Chicago Hotel epidemic of 1933. Many surveys of incidence have been made in various sections of the United States, and, although incidence has varied greatly as revealed by these studies, it is generally stated in the literature that approximately 8 to 10 per cent of the general population are infected with the parasite. As I have seen the incidence, however, it would seem to me that this figure of 10 per cent must be high. In my own work, even in cases selected for stool study on the basis of symptomatology and physical findings, I have not found this high an incidence.

Cysts of this ameba will remain viable if moist and at warm temperature as long as 3 weeks and at lower temperatures as long as 3 months. Drying kills the cysts rather promptly. Chlorine as used in municipal water purification is not effective in destroying cysts.

The disease is essentially one of filth, and, in general, those unhygienic conditions which favor the transmission of typhoid bacilli are the same as those which favor the transmission of the ameba, by means of contaminated food, contaminated water, human carriers, and flies. The use of human excreta for fertilization of vegetables as practiced to some extent in this country by certain elements of the population provides a hazard in relation to those vegetables eaten raw. The problem of animal infestation as related to transmission of the disease has been studied and infections of rats and dogs have been reported. Little is known concerning immunity to the disease, although it would seem that individuals are capable of establishing a certain degree of immunity. I have had cases giving the history of a frank dysentery many years before with spontaneous recovery from dysentery but with continued minor manifestations over the years.

The pathology of the dysenteric form of the disease is generally recognized. In the carrier state, the lesions, as known, are smaller and often microscopic. The organisms tend particularly to grow in the cecum and to some extent in the terminal ileum. The appendix is frequently involved, and in the great majority of my patients the appendix had been removed for so-called chronic appendicitis, symptoms of right lower quadrant discomfort having persisted after operation. It is my judgment that no individual with so-called chronic appendicitis should ever have an appendectomy without first having adequate studies of the stools for amebae. Chronic appendicitis is at best a doubtful diagnosis, and it may well be that many patients with right lower abdominal discomfort without characteristic attacks of acute appendicitis are in reality cases of non-dysenteric amebiasis.

It is my thought that too much emphasis has been placed on the symptomless carrier. The cases I have seen have had symptoms compatible with the known pathology of the carrier state. The outstanding manifestations which I have observed are those of right lower abdominal pain or discomfort, often a tendency to looseness, alternating with constipation or with normal stools, and certain systemic manifestations which logically may be thought due to chronic infection or to focal infection. Some patients may have no looseness at all but may have chronic constipation. In addition, a general feeling of intestinal unrest with a tendency to gaseous indigestion may be mentioned. Loss of weight and strength may be a complaint. In general, the symptomatology can be grouped under the general category of those conditions which for want of a better diagnosis are spoken of as chronic colitis.

The physical findings in the non-dysenteric group of cases are quite striking and completely in keeping with the characteristics of the disease. If, in going over the abdomen one observes a tender cecal area with a left colon not tender on palpation, and particularly, if one feels the edge of the liver, such patients should always be studied for the possible presence of amebae. This picture is not characteristic of the one observed in spastic or nervous colitis. In the latter it is common to find the left colon the sensitive portion of the bowel, rather than the right. I have long studied patients with these right-sided findings for evidence of amebae and in a fair percentage of them have identified the organisms.

As already stated, the majority of these people have had an appendectomy before coming for study. I find that the liver is involved in a mild way in the majority of the cases. Abscess formation has not occurred, but an amebic hepatitis with microscopic lesions in the organ has arisen. The pathology of this has been established by numerous investigators.

Accordingly, I would again mention the above simple findings of a tender right colon, without tenderness in the left colon, and of a liver just enlarged enough to be palpable, as adequate physical findings to justify very careful study of the feces.

At this point I wish to bring out certain observations I have made in people of this general group as related to the problem of focal infection. It is entirely logical to assume that the lesions, although indolent or minute, produced in the right colon by the ameba in the carrier or non-dysenteric state, are entirely capable of providing a portal of entry for pathogenic bacteria. In the early days of my work I found the ameba in individuals who came because of rheumatoid arthritis. These individuals had had all of the usual foci of infection removed and had continued having joint trouble. The observance of abdominal findings already mentioned promoted study of the feces. To my surprise a number of these people following identification and eradication of the ameba were relieved of arthritic manifestations. In the milder cases complete cure occurred; in the more severe cases, arrest of the arthritic process occurred.

Prompted by this clinical observation over the years, I have studied the feces of every case of rheumatoid arthritis coming under my care and have had earlier impressions confirmed by further observation of similar results. I know that this point of view is contrary to that commonly held, but I feel strongly concerning this matter and recommend continued study of this possible etiologic factor in all rheumatoid arthritic cases.

The following case report was first presented before one of our local medical societies in the winter of 1942 and is included in this report as then given:

Mr. C. G., aged 50 years, was first seen, February 23, 1940. His difficulties began in November 1919 while in the A.E.F. in France. At this time he, along with many others in his outfit, developed dysentery. A number died of dysentery and the complications thereof. He himself continued on duty. He passed much blood and mucus and continued doing so until 1929. He then was treated for ulcerative colitis, being given autogenous vaccine of Bargen's bacillus. No striking improvement followed this treatment. From 1930 on, however, he had less discharge of blood and mucus, but from time to time spells of diarrhea occurred. This state of affairs continued until about 2 years ago. Since then he has seen very little blood, and during most of the time has been constipated. At various times during the years between his discharge from the Army and the present time the patient has been hospitalized and treated. In 1929 he had a severe herpes zoster involving the fifth nerve. In 1935 he underwent a general survey in Emergency Hospital because of a very painful rheumatic condition of the spine.

Since 1935 the patient's greatest difficulty has been in the nature of rheumatism involving particularly the spine, but to some extent other joints, especially the shoulder joints. It was for relief of this rheumatism that the patient came for study. In an effort to secure relief of this rheumatic difficulty the patient had had his tonsils removed, various teeth extracted, his antra washed out, and all other usual foci of infection investigated. Physical examination revealed no evidence of focal infection in any of the usual locations. Examination revealed tenderness over the upper dorsal spine and marked tenderness over the right shoulder joints with limitation of motion. The cecum was found quite definitely tender, and the liver was enlarged downward a hand's breadth and sensitive to pressure. Physical examination was otherwise negative.

Routine laboratory studies revealed little of significance. A series of examinations of stools secured after the administration of citrate of magnesia were reported as negative for amebae. In all, 10 stools were studied by a very capable pathologist.

X-ray examination of the gastrointestinal tract revealed no evidence of an organic lesion. A barium enema revealed no evidence whatever of ulcerative colitis. X-ray examination of the spine revealed osteoarthritic proliferation along with areas of mild atrophic change. X-ray examination of the shoulders revealed mild atrophic changes.

Although the clinical findings and history naturally made one suspect amebiasis, the negative reports on so many stools prevented this diagnosis. Accordingly, for a period of time this patient was treated on a symptomatic basis, and nothing was accomplished for him. His rheumatic difficulties steadily increased, and finally, in order to relieve the patient of pain in the entire spine, Dr. Milton Cobey applied head traction at Doctors Hospital on a fracture board. Thereafter he gave the patient a Taylor spinal brace with a jury-mast support for the head. This held the spine entirely rigid. The patient wore this brace for a number of months and only with it was he able to secure a certain degree of relief. Radicular pains became a feature of the patient's case at this time.

Finally in May of 1941 I again studied the stools for amebae and established the presence of both the vegetative and encysted forms of Endamoeba histolytica. Immediately the patient was given a course of 10 grains (0.65 Gm.) of emetine hydrochloride hypodermically and 2 10-day courses of carbarsone, $3\frac{4}{5}$ grains (0.25 Gm.) twice daily, the courses being separated by a week in which the drug was not given. Re-study of the stools on July 20 and again 2 weeks later revealed no evidence of amebiasis.

The clinical response of this gentleman has been remarkable indeed. From a state of semi-invalidism necessitating the constant use of a spinal brace, he has gone into a level of health compatible with normal activity. I have had the pleasure recently of hunting quail with him on his estate, and I may say that he stood a hard day's hunt as well as I.

This patient remained well until his death in 1942 of a cerebral hemorrhage.

In the study of feces for the identification of amebae, I follow these simple instructions:

1. On ______ eat a light supper.

2. At bedtime take six (6) teaspoonfuls of Fleet's Phospho-soda in a full glass of cool water.

3. Save the first and third stools passed in separate sealing containers such as a mason jar.

4. Label no. 1 and no. 3 with your name and bring to the office the next morning.

Fleet's Phospho-soda seems to be a fairly satisfactory drug, although any saline may be used. A saline serves the purpose of pulling the parasite away from the intestinal wall.

The examination of the third stool passed, a watery stool, more often reveals the ameba than the examination of the first or formed stool. Specimens are sent promptly to the laboratory for examination. Direct study of fresh smears is made and direct study of concentration of the liquid specimen is made. Cultures are also made on the St. John media, a media growing only the Endamoeba histolytica of intestinal amebae. Cultures are also made on a media which will grow only Dientamoeba fragilis.

The identification of amebae is difficult. I have never seen a laboratory technician capable of doing reliable work in this field. I think that the work must be done by a physician pathologist or protozoologist.

The treatment for the eradication of the Endamoeba histolytica is simple but not always effective. Not infrequently it must be repeated. I commonly give a 20-day course of Diodoquin 3⅕ grain (0.21 Gm.) pills, 3 after each meal, 9 a day, for 20 days. During the first 6 days of this treatment, I administer a grain of emetine hydrochloride hypodermically daily. It has seemed to me wise to use this drug, although it is often said that it should be used in dysenteric states only. It has a marked specificity for the amebae, and as already stated, I believe that in the carrier states amebae do exist deep in the tissues where this drug is supposed to have its greatest influence. It is also specific for amebic hepatitis when such is present. I see no need of denying the patient whatever benefit it may yield. Following the Diodoquin I give the patient carbarsone, either 3⅘ grains (0.25 Gm.) 3 times daily for a week or twice daily for 10 days in 2 courses separated by a week in which the drug is not given.

There is a slight danger in the administration of carbarsone. An occasional case of arsenical peripheral neuritis may result from its use. The patient may be cautioned to report any tendency to leg weakness particularly in stepping up, and if reported, the drug must be abandoned.

I feel that the results obtained from the eradication of the amebae in these non-dysenteric states are extremely gratifying. It has seemed to me that not only is relief obtained from colonic discomfort and irregular stools and intestinal gaseous indigestion, but that the general health level and vitality of these patients are greatly improved. Also, as already indicated, the gratifying cure or relief of rheumatoid arthritic manifestations when they do occur is cause for great gratification.

The following case reports are briefly summarized to illustrate the symptomatology and findings of the ameba carrier state.

Mrs. M. B. S., aged 39 years, seen August 3, 1925, came because of recurring attacks of bowel looseness, intestinal "gas," and of general fatigue. A diagnosis of spastic colitis was made and the usual treatment for this disorder outlined. She did not do well and reported to the office over a number of years up to 1934. At the original examination, the liver could be felt 2 fingerbreadths below the costal margin, and there was tenderness over the colon, particularly the right colon. Examination of the stools in 1925 was negative for amebae, the study being done by the office technician. In 1934 the Endamoeba histolytica was identified, and the patient treated for amebiasis. Careful follow-up studies after treatment failed to reveal the amebae. This patient has been seen over the years for minor considerations such as respiratory infections, and she has been entirely well of her digestive trouble.

Mr. J. A. S., aged 48 years, first came for examination, April 8, 1921. The history to be given in connection with this man is a rather unpleasant one to record.

He came because of general exhaustion, headache, lower abdominal discomfort, and joint pain. Little was accomplished for him, for in those days we often made the diagnosis of nervous colitis, even then having in mind much in the way of psychosomatic medicine. Finally in 1933 Endamoeba histolytica was identified. He was treated and improved greatly. The symptoms which led to the discovery of the ameba were prompted by cecal tenderness and slight enlargement of the liver.

I lost sight of the patient until late 1945, when he again presented essentially the same picture but with evidence of rheumatoid arthritis. Study of the stools again revealed the ameba, and again he was treated, under the direction of the doctor in his home town.

Now he again reports in, more disabled than ever, with Endamoeba histolytica still present in his stools and with rather definite evidence of an amebic abscess of the liver. The arthritic process has further progressed. He still has a markedly tender cecum in addition to the liver findings.

Mrs. C. C., aged 28 years, seen May 23, 1944, was sent in by an ophthalmologist because of a retinitis with a request that a study for any possible source of infection be made. A general study revealed no focal infection in the usual areas. I had found her husband to have amebiasis about a year before. The cecum was found to be tender; the liver could not be felt. Largely because of the husband's illness, I studied the stools, and identified the Endamoeba histolytica, and prescribed treatment. Her difficulty cleared up. This patient is a personal friend; I have followed her case through the years, and she has been well.

Mr. B. P., aged 45 years, seen January 8, 1945, came in because of discomfort in the right side of the abdomen. The survey revealed the liver to be palpable just below the right costal margin and a tender cecum. The Endamoeba histolytica was identified and eradicated. The liver returned to normal size. I have followed this patient through the years. He has since had a coronary occlusion from which he has had a good recovery. He has never had a return of abdominal pain. Diarrhea had never been a feature of his case.

Mrs. W. M. B., aged 49 years, seen June 26, 1940, came because of painful swelling of certain of the large joints. The general examination revealed little. The liver was not enlarged. An appendectomy and cholecystectomy had been done 13 years before. No focal infection was observed in the usual areas, but Endamoeba histolytica was found in the stools and eradicated. Following eradication of the ameba, all joint symptoms ceased. She has been followed to date and has not had a recurrence of such.

Mr. R. S. P., aged 34 years, seen first on September 24, 1945, came because of discomfort in the right lower abdomen and intestinal "gas," and a tendency to soft and occasionally loose stools. He was sent by a surgeon whom he had consulted thinking that he had appendicitis. The study revealed a tender, sensitive cecum, and the liver was palpable. Endamoeba histolytica was identified. After eradication he recovered, and he has remained symptom-free to the present date.

In my practice, as you may well visualize from what has already been said, I do a great deal of work on the feces. In the general course of this I have encountered a group of patients who have had mild intestinal difficulty in whom I thought I might find the Endamoeba histolytica but in whom I would have reported only the presence of Dientamoeba fragilis. These patients were largely individuals who came because of mild bowel looseness in whom careful study had revealed no satisfactory explanation of this looseness.

Although I had long accepted the usual point of view that Dientamoeba fragilis was a harmless parasite, for want of something more logical to do, I set about eradicating this parasite, and I have seen enough of this to make me wonder if this organism may not also be of some importance, although of much less importance than the Endamoeba histolytica.

With this parasite I have not observed the systemic manifestations or the evidences of focal infection of Endamoeba histolytica infestation, and I have not observed the bowel tenderness or the hepatic involvement of the latter. There is no evidence that Dientamoeba fragilis is a tissue parasite. The parasite is easily eradicated by carbarsone and to a less extent by Diodoquin. There is no reason to give emetine.

It may be of interest to recall the presenting symptoms of this fragilis group. In the last 19 seen, 6 came because of bowel looseness, 6 because of low-grade abdominal pain, 4 because of general fatigue, and 3 because of manifestations not related to the intestinal tract.

I have as yet no definite convictions concerning the importance of Dientamoeba fragilis. I merely mention the problem to point out that in my limited experience with this organism, certain individuals with milder chronic diarrheal states have had cessation of symptoms with eradication of the parasite. All of my patients have had follow-up studies after treatment.

LATE MANIFESTATIONS OF TROPICAL DISEASES*†

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During the War many writers, both lay and professional, repeatedly called attention to the possible public health hazards likely to result from the large numbers of American troops being exposed to tropical and exotic diseases throughout the world. It has now been just a little over a year since the War ended. During this period millions of men and women, who a few months ago were wearing the uniform in some of the most disease-ridden corners of the earth, have returned and resumed their places in the civilian community. As physicians, it is entirely proper that we now review our wartime medical experiences to see wherein our original estimates of the medico-military problem were confirmed, to discover wherein anticipated problems failed to materialize, and then, from such a study, to decide whether a postwar appraisal of the tropical disease hazards can be made.

Some five years ago it was becoming increasingly apparent that, unless something unforeseen developed to change the course of events, it was only a question of time until we would be forced into war. By simple comparison of the disease maps of the world with the war map it was obvious that this would be a war in which tropical diseases would assume a major role. And of the tropical diseases dysentery and malaria stood forth prominently as military problems; the former because during the initial stages of combat it is inevitable that conditions favorable to its development will prevail, and the latter because, in addition to its worldwide tropical and subtropical distribution and the almost herculean task of vector control, our troops were almost universally susceptible. Further, the unhappy history of the British, French and Germans with malaria in World War I and our own experience in 1898 were too recent to be forgotten.

Although it was conceded that these two diseases would doubtless be our foremost problems, it was also evident that, with the exception of yellow fever, for which we had an effective vaccine capable of producing lasting immunity, few of the so-called tropical diseases could be completely disregarded. Depending upon their epidemiology, clinical course, prevalence and history, some, such as dengue, tyhus, cholera, plague and schistosomiasis were, obviously, of more immediate concern than others.

Remembering that returning military personnel had been credited with starting the various epidemics of typhus and malaria in Europe after World War I, and that, in times past, cholera, plague and dysentery had dogged the footsteps of the returning soldier, it was with justified concern that alert physicians began to question the effect on community health of the mass return of individuals who had acquired a tropical disease. With one exception the opinions were almost as numerous and varied as the men who gave them.

The danger to a community from an imported disease, especially a tropical disease, is dependent upon several factors: the climate, the standards of housing and sanitation, the incubation period of the disease, the period of infectivity, the presence of a vector, and, in the case of a disease already present, the introduction of a different or more virulent strain of causative organism to which local immunity is absent or incomplete.

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* Read before the 17th Annual Scientific Assembly of the Society, September 30, 1946.

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Obviously, the chronic diseases having a long incubation period are more dangerous than those having an acute course with a short period of communicability. When considered from these viewpoints, there was universal agreement that potentially malaria was the greatest postwar threat to community health. That other diseases had their possibilities was not overlooked, but by comparison the dangers appeared relatively insignificant.

With this synopsis of the estimate of the situation as it presented itself immediately before and shortly after our entry into the War, let us now see what did happen. Throughout the War, the land, air and sea forces were so closely integrated that, irrespective of the theatre, the personnel of all services were present and generally exposed to the same hazards. In certain instances, due to the assignment of troops into an area of marked hyperendemicity, the personnel of one service would bear the brunt of a particular disease, but on the whole the experiences of the Army and Navy were quite comparable.

As will be noted from the accompanying table only four diseases were encountered with sufficient frequency to be of major importance; these were dysentery and diarrhea, malaria, infectious hepatitis, and dengue. The prominent position assumed by infectious hepatitis with its 192,380 admissions, for an incident rate of approximately 1,700 per 100,000 troops, originally was not anticipated. Diseases occurring less often, but still of sufficient frequency to be considered significant, are shown in group II. Of these the professional and lay press had conditioned us to expect filariasis. One theatre was responsible for most of the cases of sandfly fever, and due to the areas in which our troops were forced to serve and the conditions under which they were compelled to fight, the presence of hookworm disease was not unexpected. The next two groups show the relatively infrequent occurrence of other tropical diseases which it was originally believed might be of some concern.

TROPICAL DISEASES OF MAJOR IMPORTANCE

Bacillary Dysentery and Diarrhea. In keeping with previous military history, dysentery and diarrhea were again the principal causes for admission in World War II. Present estimates place the number of admissions for these two causes at 756,849 for an admission rate of approximately 6,700 for each 100,000 persons serving overseas. As is well known, these conditions are dependent upon poor sanitation and personal hygiene. Throughout the War, as objectives were won, as units became established and sanitation improved, the disabilities from this cause subsided, only to recur at the time of the next operation. That the incidence was no higher was due no doubt to the widespread use of DDT in fly-control work during the late stages of the War.

Fortunately most of the cases of true dysentery have been of the paradysentery type, and with sulfonamide medication, especially sulfadiazine, the disease has been generally mild and practically free of sequelae. Stool surveys on Navy personnel indicate that few cases have become persistent carriers. At the present time in our service hospitals we seldom see a case of chronic dysentery, a fact indicating that this disease presents no great problem to the returnee or to the local physician. With our standards of sanitation it is believed that the danger to public health is no greater than that already present.

Malaria. The military importance of malaria is indicated by the present figures, which reveal that there were 574,613 admissions for this cause during the War.* As has been pointed out, initially its importance as a postwar problem could be only surmised, and even now it is difficult to evaluate in terms of public health. That various strains of malaria with differing clinical characteristics exist within the species has been well established. In general, the malaria contracted in the African and European theatres has behaved as did that already present in our own South. But two years ago Butler and Sapero[1] pointed out that the P. vivax malaria being contracted in the Pacific area was more serious and differed considerably from the domestic variety. They showed that the disease was much more chronic (estimated mean course of about 2 years), that, per infection, the relapse rate was 2 to 3 times that of our own vivax malaria, and finally that the American Negro was equally as susceptible as the white man, a finding of considerable importance when the well-known tolerance of this race to the American strain is recalled.

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* The Army figure of 460,872 includes cases hospitalized because of primary or recurrent attacks; the Navy figure of 113,741 is for primary attacks only.

Although Anopheles quadrimaculatus, the principal vector of malaria in the United States, is capable of transmitting the Pacific strain of P. vivax, there is as yet no evidence that this strain has been introduced into this country. Fortunately, as the War moved out of the malarious areas, most of these cases apparently

TABLE 1*

Occurrence of Tropical Diseases in U. S. Armed Forces Serving in World War II Period 1942–1945 Inclusive

	ARMY	NAVY AND MARINE CORPS	TOTALS	APPROXIMATE RATE/100,000
I. Diseases of major importance (more than 100,000 admissions)				
Bacillary Dysentery and Diarrhea	523,449	233,400*	756,849	6700
Malaria	460,872	113,741	574,613	5100
Infectious Hepatitis	171,691	20,686	192,380	1700
Dengue	84,094	37,663	121,757	1100
II. Diseases of significance (from 10,000 to 100,000 admissions)				
Hookworm	13,000*	7,209	20,209	180
Filariasis	2,152	12,040	14,192	125
Sandfly Fever	12,438	239	12,667	110
III. Diseases of minor importance (from 1000 to 10,000 admissions)				
Typhus, Scrub	6,751	575	7,326	65
Dysentery, Amebic	3,051	1,632	4,683	41
Schistosomiasis	1,636	46	1,682	15
IV. Diseases occurring rarely or not at all (less than 1,000 admissions)				
Typhus, Endemic	437	372*	809	7.2
Leishmaniasis	346	16	362	3.2
Relapsing Fever	220	22	242	2.1
Smallpox	116	10	126	1.1
Typhus, Epidemic	64	41*	105	0.93
Yaws	9	22	31	0.27
Leprosy	21	0	21	0.18
Cholera	14	0	14	0.12
Trypanosomiasis	2	3	5	0.04
Plague	0	0	0	0.00
Yellow Fever	0	0	0	0.00
Estimated number who served overseas	7,300,000	4,000,000	11,300,000	

* Data derived from official sources still in process of compilation and editing. Where indicated by asterisk, estimates only are available at present time. Although tentative, presented data reveal the very marked incidence of only 4 diseases and the remarkably low incidence of almost all other tropical diseases despite massive exposure of large numbers of troops.

"burned themselves out," so it would seem that the grand opportunity for its introduction has now passed. It is still too early, however, to accept the idea that this will not occur. Should it happen, not only will the clinical course of the introduced disease be more severe but as Sapero[2] points out, our Negro population in the South may suffer seriously.

In 1943 our service hospitals were filled with cases of malaria. Today only occasionally do we see a case and those which we are seeing, like those which the practicing physician will be called upon to treat in the returnee, are, almost without exception, benign tertian infections. There are three basic reasons why this is so. First, benign tertian malaria is fundamentally a chronic disease with a tendency to repeated relapses, and this Pacific strain appears to exhibit this quality to a high degree. Second, quartan malaria, a disease of even greater chronicity, but characterized by less frequent relapses, has been acquired by relatively few persons. And third, malignant tertian malaria, seen not infrequently during the early stages of the War, is a disease of comparatively short duration, responds readily to adequate therapy, and does not tend to recur. Further, the dosage of atabrine used suppressively to prevent the "clinical breakthrough" of P. vivax malaria was apparently sufficient to completely prevent or eradicate this infection. As a result, only under special circumstances is this disease seen in returning service personnel.

During the early part of the War many of the men evacuated from combat areas because of frequent and repeated relapses exhibited the usual mild to moderate secondary anemia. But with removal from the enervating environment and treatment in hospitals especially selected as to staff and location, recovery was rapid. Even in these most persistent cases the syndrome of "malaria cachexia" has occurred rarely, if at all, and to date there have been no reports of other sequelae.

When we remember that, doubtless, during the past three years in spite of all precautions, many infected men in the process of leave, reassignment or rehabilitation have visited all parts of the country without any serious consequences to the public health, the outlook is not too discouraging. But the potential hazard is present and warrants a continuation of maximal efforts directed toward the control of this disease.

Infectious Hepatitis. The case incidence for this disease, 192,380, includes those cases reported under such varying titles as acute hepatitis, infectious (epidemic) hepatitis, acute infective jaundice, and homologous serum jaundice.

It is now generally accepted that these diagnostic titles represent the same disease, the etiology of which is most likely a filterable virus. In spite of the enormous amount of work done here and abroad during the past few years, the causative organism has not been isolated, as Havens[3] points out, "in the sense that it has been seen, cultured, or transmitted experimentally to laboratory animals." However, the work to date clearly shows that, not only during the acute phase of the disease but also prior to the onset of symptoms, the infectious agent is present in the feces and blood and possibly at times in the urine and nasopharyngeal secretions also. Under natural conditions the most probable mode of transmission is via the alimentary tract as in dysentery, more rarely as a droplet infection through the nasopharynx. Artificial transmission occurs through the parenteral injection of infected blood or blood products. The exact duration of infectivity has not been definitely determined.

There is considerable clinical and some laboratory evidence[4] to support the concept that an attack of the disease produces at least a strain immunity. How then do we explain the occasional recurrences of the disease unless on the basis of several strains of the organism, the loss of a transitory immunity, or the loss of an immunity which is dependent upon the persistence of a latent infection, so called premunition? It is important from the standpoint of public health that we obtain these answers.

When transmission is via the intestinal-oral or the nasopharyngeal route, our usual hygienic precautions should suffice to prevent its spread. The principal postwar danger lies in the possibility of artificial transmission through the therapeutic use of blood from donors harboring the virus. During the War the development of a significant number of cases of "homologous serum jaundice" from the therapeutic use of blood and blood products obtained from donors who doubtless were in the subclinical or "preicteric" stage of the disease, has shown that human plasma is not an entirely innocuous therapeutic agent. With the recognition of this danger research efforts have been directed to meet the problem. But until this problem has been solved the use of pooled lots of serum, plasma or blood is not advised, because, as has been adequately demonstrated, with multiple recipients a larger number of cases of hepatitis might develop should one of the donors be infectious.[4] With this knowledge, the physician must carefully evaluate the expected therapeutic advantages against the dangers involved.

Other features of interest are the variable incubation period of the disease (from 2 weeks to 4 months, usually slightly over 3 weeks but dependent upon the mode of transmission), the fact that occasional cases never develop clinical jaundice, that during an attack only approximately 75 per cent complain of tenderness in the liver area with or without enlargement of that organ, and that a small percentage of cases may develop cirrhosis. Rarely the disease runs a fulminating course to a fatal termination.

Infectious hepatitis may well become a postwar problem of real significance and cannot be lightly dismissed.

Dengue. Dengue, the last of the diseases having better than 100,000 admissions, should present no postwar problem. In the South, where the mosquito vector is present, epidemics of this disease have occurred from time to time in the past. Although convalescence may be prolonged, recovery is complete and without sequelae. Due to the short period of infectivity and because of the time generally required to return a person to the United States, so far as is known this disease has not been reintroduced by returning service personnel.

DISEASES OF SIGNIFICANCE

In this group it will be noted that there are only three diseases and that the combined total admissions for all were less than one half that for dengue alone.

Hookworm. From the standpoint of public health this disease should offer no great problem. On the basis of prewar and postwar surveys of military personnel we feel confident that the indicated incidence represents only a fraction of the number who acquired this infection. Fortunately, most of the cases have not been heavily infected and even without treatment should lose their infection spontaneously. However, since some of the acquired infections have been with A. duodenale, the possibility that this species may be introduced into some of the more poorly sanitated rural areas of our South cannot be overlooked.

Filariasis. Because of the incapacitating nature of the primary attack and the tendency to repeated relapses over a long period of time, three years ago filariasis was a disease of no little concern. Never before had there been such massive exposure of nonimmune whites in such a short period of time, and with the reappearance of clinical symptoms in infected persons over and over again we had cause to wonder as to the final outcome. Would it progress to deforming and disabling elephantiasis?

Today, on the basis of studies by both the Army and Navy, especially those of Coggeshall[5] and his group at Klamath Falls, Oregon, we can say that few, if any, permanent disabilities will result from this infection. By the immediate removal of infected persons from the endemic areas, the degree of exposure was insufficient to produce an infection which the body could not handle. Removed from the source of reinfection most of these cases proved to be self-limiting in about two years. Although today we still see an occasional individual complaining of mild transitory symptoms, the findings have been minimal, and it is questionable if, in civilian life, they would seek medical attention. Even in these most persistent cases, the attacks are becoming progressively less severe, frequently lasting less than 72 hours, and recurrences are at gradually lengthening intervals.

From the standpoint of public health there are two factors mitigating against the establishment of this disease in the United States. The vast majority of these infections were acquired in the Samoan area, and the work by Byrd, St. Amant and Bromberg[6] shows that it is practically impossible to infect Culex quinquefasciatus, the classical vector of this disease present in the United States, with the Samoan strain, and when infection does occur, only rarely does the parasite mature to the infectious stage. Clinical cases have been studied repeatedly, and only on exceedingly rare occasions have microfilaria been found in the blood stream. Since the exposure of large numbers of individuals exhibiting a marked filaremia to massive numbers of the suitable vector is necessary in order to establish and maintain an endemic focus, the likelihood of filariasis becoming a postwar problem is now considered remote.

Sandfly Fever. The short period of infectivity, the absence of acute cases as a source of infection, and the apparent absence of a suitable vector in this country render the postwar spread of this disease unlikely.

Diseases of Minor Importance

Scrub Typhus. With few exceptions this disease was acquired only in restricted areas of the Southwest Pacific or in the China-Burma-India theatres. When not ending fatally, recovery apparently has been complete and free of sequelae. Because the vector is absent in this country it should present no postwar problem.

Amebic Dysentery. This disease, which was of minor military importance, may well present definite postwar problems. As with hookworm, we feel reasonably sure that the reported incidence does not indicate the number of infections actually acquired. The problem will not be one of adjusting to a new disease, since already the etiologic agent, E. histolytica, is known to be present in approximately 10 per cent of the population. The problem will be one of an addition to the reservoir of carriers and the difficulties in the recognition of the infection. Latent and chronic infections with this organism, as is well known, frequently present many vague and obscure symptoms. The complication most generally feared is abscess of the liver, a condition which frequently does not appear for 2 to 3 years after the initial attack of dysentery. A point of interest to the internist and the surgeon alike is that, during the 4 war years, this complication occurred 66 times in Naval personnel, and in 50 it was reported without a definite history of antecedent dysentery.

Schistosomiasis. No effort has been made to break down the incidence figure for this disease according to the type infection, but the major portion of these infections were acquired in one theatre. Personnel of all exposed units have been carefully studied, and intensive curative therapy has been given to those found infected. It is believed that these individuals are now cured and no longer can be considered a source of danger. Further confirmatory evidence that this disease will be of no postwar significance is the fact that, to date, we have been unable to obtain cercariae from any of the North American snails infected with the various species of Schistosoma.[7]

DISEASES OCCURRING RARELY OR NOT AT ALL

Typhus Fever. Typhus fever, a dreaded disease of former wars, was responsible for only 914 admissions during World War II, and of this number approximately 90 per cent were of the endemic type contracted in this country rather than overseas. The remarkably low incidence of epidemic typhus, only 105 cases, speaks well for the effectiveness of the vaccine and dusting powder used by the military forces for protection against the louse-borne infection. With our standards of living and personal hygiene it appears that these conditions offer no postwar problem.

All Others. Considering the large numbers of troops involved and the areas in which they operated it is interesting to note that the other diseases, which originally we believed might occur with some frequency, actually were encountered rarely or not at all.

With a highly effective vaccine, the finding of 126 cases of smallpox was somewhat unexpected, but a study of these cases, in so far as possible, has shown that none had ever been successfully vaccinated. Although the number is small, the recent occurrence of 2 localized outbreaks of the disease traceable to returning service personnel indicates that this disease may be of some postwar significance, not so much from the returnees as from other individuals arriving by air from highly endemic areas while still in the incubation period. To combat this danger, not only must successful vaccination be a requirement for international air travel, but, through vaccination, effective group immunity must be developed and maintained in our civilian communities. Also, our quarantine officers must be even more alert to detect and prevent the entrance of persons with this disease into the country.

At the present time there is certainly no evidence to indicate that the remaining diseases which were encountered only rarely, leishmaniasis, relapsing fever, yaws, leprosy, cholera, and trypanosomiasis, will offer any problem with regard to postwar health in this country.

SUMMARY

A brief resumé has been given of the estimate of the tropical diseases as potential military and public health hazards at the outbreak of war with presentation of data indicating the frequency of their occurrence in military personnel during the war years. Of the so-called "tropical diseases" those most frequently encountered, in order of incidence, were bacillary dysentery and the diarrheas, malaria, infectious hepatitis, and dengue, each of which were responsible for admissions in excess of 100,000 (table 1). Considering the areas in which our troops served, the incidence of the other diseases of this group was remarkably small.

From the standpoint of public health, malaria, infectious hepatitis, and possibly amebic dysentery and smallpox are the only diseases of apparent postwar importance. From the standpoint of late manifestations, these have been characterized by their absence. At the present time it can be said with reasonable assurance that rarely, if at all, will the physician in general practice be called upon to treat in the returnee any conditions other than those with which he is already familiar.

BIBLIOGRAPHY

1. Butler, F. A., and Sapero, J. J.: Postwar tropical disease problems in United States. South. M. J., 1945, **38**, 459.
2. Sapero, J. J.: Tropical diseases in World War II returnees. New England J. Med., to be published.
3. Havens, W. P., Jr.: Epidemiological studies on infectious hepatitis. Am. J. Pub. Health, 1946, **36**, 37.
4. U. S. Navy Dept.: Role of blood and blood derivatives in homologous serum hepatitis. Bumed News Letter, 1946, **7**, no. 11, p. 19.
5. Coggeshall, L. T.: Personal communication, 1945.
6. Byrd, E. E., St. Amant, L. S., and Bromberg, L.: Studies on filariasis in Samoan area. U. S. Nav. M. Bull., 1945, **44**, 1.
7. Stunkard, H. W.: Bimonthly Progress Report no. 13-OSRD contract OEM Com. Med. Res. -369, October 15. 1945.

THE NATIONAL HOTEL EPIDEMIC OF 1857

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THE epidemic which originated from the National Hotel in Washington during the winter of 1857 has been a favored subject for newspaper Sunday editions for almost a century. The news value of the epidemic may be attributed in large part to the aura of mystery which has come to surround the origins of the epidemic. The medical men of the time attributed the sickness to sewer gas which they believed had permeated the hotel from defective sewers.[1] The hypothesis that sewer gas can cause disease has since been proved erroneous,[2] but no attempt has been made to review the epidemic with the idea of uncovering the real nature of the sickness.

The year 1857 was a presidential inauguration year. Thousands of strangers were descending upon Washington anticipating jobs and opportunities under the spoils system. According to the *Evening Star* of February 24, 1857, the influx was much greater than for any previous inauguration. The daily papers carried long lists of new arrivals at the local hotels. President-elect James Buchanan arrived on March 3. He was accompanied by his niece and nephew, Miss Harriet Lane and Eskridge Lane, and Vice President-elect John C. Breckinridge and wife. The party was driven from the train in an open barouche to quarters at the National Hotel.[3] Of the members of the Presidential party, Eskridge Lane died within 4 weeks as a result of the epidemic.[4] As far as is known President Buchanan did not suffer any ill effects.

A fairly accurate account of the epidemic can be outlined from the report to the Board of Health. This report resulted from a resolution adopted by the Board of Aldermen of the City of Washington authorizing the Mayor and the Board of Health to examine into the cause of the sickness at the National Hotel.[1]

The epidemic began during the latter part of January and continued with the exception of 2 weeks in February until about March 16, when the hotel was closed.[1] According to the testimony given in the report to the Board of Health[1] the attacks came on suddenly, usually early in the morning. Bowel movements were frequent, the stools thin, light-colored and frothy or yeasty. Vomiting frequently occurred and the patient often became quite dehydrated. The disease tended to be recurrent in the same patient and would sometimes continue for several weeks. How many contracted the disease was not known, but it was evident from contemporary correspondence that there were several deaths and many cases of prolonged illness. An account from the *Newark Daily Advertiser* of March 13, 1857 read: "Several persons while at Washington took water from the National Hotel which had been poisoned by the rats and were made very sick thereby. One or two deaths have already occurred." A note from the *New York Herald*, which appeared in the *Evening Star*, March 21, 1857, gave a version of the epidemic as a guest from New York saw it. "Peter Cooper states there were 100 inhabitants at the hotel at the time he was attacked and that nearly all were seized within 24 hours. The attack commenced with distress of the stomach, nausea and vomiting, accompanied with or followed by diarrhea and severe tenesmus." In another note of the same date Mr. Cooper stated that some of his acquaintances had died from the disease.[5] A letter to the *Evening Star* which appeared March 23, 1785, concerning a Mr. H. W. Sneed of Tennessee stated that Mr. Sneed was still suffering from the National Hotel disease and had not been able to reach his home. At the time of the letter Mr. Sneed was lying in bed in Greenville, Tennessee, in a critical condition.

"One of the greatest sufferers seems to have been the chief cook."[1] He was among the first to develop diarrhea, and it lasted for 6 or 7 weeks. Sometimes he would have as many as 20 bowel movements a day. All the cooks, 5 in number, had been sick. At one time there was so much sickness among the servants that the regular duties of the house were interrupted.[1]

The important events of the epidemic could be summarized chronologically as follows:

1. The disease appeared during the latter part of January 1857.
2. The epidemic subsided during the last 2 weeks of February. These 2 weeks were characterized by warm, mild weather.
3. The epidemic again became very rife about March 1, at which time there was return of cold weather.
4. March 3, 1857, President-elect Buchanan arrived at the National Hotel accompanied by his niece and nephew, Harriet Lane and Eskridge Lane.
5. March 16 was the last day a list of arrivals at the National Hotel appeared in the *Evening Star*.[6] Presumably the hotel was closed on this date.
6. March 17, the Board of Aldermen adopted a resolution authorizing the Board of Health and the Mayor to examine into the cause of the sickness at the hotel.[6]
7. March 21, letters from other cities began to arrive in Washington describing the continued illness and sometimes death suffered by departed guests from the hotel.[5]
8. March 24, the report to the Board of Health was published.[1]
9. March 27, James B. Henry, private secretary of President Buchanan, left Washington accompanied by Miss Harriet Lane to attend the funeral of Eskridge Lane who had died of the National Hotel disease.[4]

A review of the sanitary conditions as they existed in Washington in 1857 throws an interesting light on the background of the epidemic. As was stated earlier, all of the cooks and a majority of the hotel's servants suffered severely from the disease. The opportunities for contamination of the hotel's food supply were obviously extraordinarily good.

The sewage of at least one third of the city drained into the old city canal which flowed along a part of what is now Constitution Avenue. The canal had a very sluggish flow and as a result became seriously polluted. The market area, where now stands the Archives Building, did not help matters, since the market people emptied all of their refuse into the waterway.[7] The hotel's sewage emptied into the Sixth Street sewer,[1] which in turn flowed into the canal one block away.* The cellar of the hotel evidently had a direct open connection with the sewer. According to the testimony of a sewer builder, Mr. J. T. Terry, there was an opening in the southwest corner of the cellar connecting with the sewer.[1] Through this hole there was continually passing a current of fetid gas.

The source of water was the city spring which was located on "C" Street not far from the hotel. The water may have been conveyed to the hotel by wooden pipes, since the city laid wooden pipes to carry water to running pumps on Sixth and Seventh Streets, south of Pennsylvania Avenue.[8] It takes no stretch of the imagination to see how this water supply could have been heavily contaminated by ground seepage from the leaky and obstructed sewers.

The diseases which commonly appear when sewage, water and food become intermixed or when food is contaminated by infected food handlers are typhoid fever, cholera, and the dysenteries. From the discussion of these cases in the daily papers it appears that not many guests contracted typhoid fever. The symptoms were not typical, and it was the wrong season of the year, typhoid fever being a late summer and autumn disease.[9] The attending physicians would have easily diagnosed an epidemic of typhoid fever, since they were all familiar with its manifestations. Cholera had been epidemic in Washington in 1832,[7] but the National Hotel epidemic did not seem to be cholera. A guest of the hotel wrote the *Evening Star*, March 16, 1857: "As a boarder of the house I would say for the benefit of misinformed persons that I believe there is no guest here having symptoms of cholera or anything tending to cholera." A point against the diagnosis of cholera is the fact that cholera is a short-term disease. In untreated cases which progress to fatality death usually occurs within 48 hours after onset of symptoms. However, if the patient survives for 5 days he may be expected to recover and not continue to experience intermittent attacks of diarrhea.[10]

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* The National Hotel was located at Sixth and Pennsylvania Avenue, N.W.

In reading over the accounts of the epidemic one is struck by the similarity of this hotel disease with the explosive outbreak of amebic dysentery which occurred in Chicago in 1933.[11] However, as has been pointed out, the clinical features of an acute attack of amebic dysentery are similar to that of bacillary dysentery.[12] One differential point is that the National Hotel disease seemed to have a rather short incubation period. This fact is evident from the testimony of Peter Cooper when he wrote that at the time of his attack nearly all the guests of the hotel were seized within 24 hours. This would indicate that if the epidemic were a dysentery it was probably predominantly bacillary rather than amebic in origin. The incubation period for acute bacillary dysentery is about 2 to 7 days,[13] whereas the incubation period for amebic dysentery is longer and more variable. Walker and Sellards in 1913 reported an experiment in which 20 human volunteers swallowed fecal material containing cysts of Entamoeba histolytica. Of this group of 20, 18 were parasitized. Four of the 18 developed intestinal amebiasis. The incubation period for this group of 4 cases varied from 20 to 87 days.[14] Although no mention was made of blood in the stools, the description as given, "thin, light-colored, frothy or yeasty," would fit in with the present-day conception of a bacillary dysentery stool in the early phase of the disease.[15] The stool of amebic dysentery typically contains a certain amount of fecal material mixed with blood and mucus.[12]

CONCLUSION

The National Hotel epidemic of 1857 was probably a dysentery, either amebic or bacillary. A combination of the 2 types would not have been unlikely. Sources for contamination of the hotel's food and water were numerous. Sewer gas played no part in the etiology of the epidemic.

BIBLIOGRAPHY

1. Report to the Board of Health. Evening Star, March 24, 1857.
2. Boyd, M. F.: Preventive Medicine, 4th ed. Philadelphia: Saunders, 1932, p. 159.
3. Evening Star, March 3, 1857.
4. Ibid., March 27, 1857.
5. Ibid., March 21, 1857.
6. Ibid., March 17, 1857.
7. Cholera in 1832 made medical history. Sunday Star, January 14, 1934.
8. Zevely, D.: Old Houses on C Street and Those Who Lived There. Records of Columbia Historical Society, 1902, **5**, 175.
9. Cecil, R. L., editor: A Textbook of Medicine, 4th ed. Philadelphia: Saunders, 1937, p. 222.
10. Meakins, J. C.: The Practice of Medicine, 3rd ed. St. Louis: Mosby, 1940, p. 662.
11. Bundesen, H. N., Tonney, F. O., and Rawlings, I. D.: J. A. M. A., 1934, **102**, 367.
12. Bockus, H. L., and others: Gastro-Enterology. Philadelphia: Saunders, 1944, **2**, 627.
13. Cecil, R. L., editor: See ref. 9, p. 240.
14. Walker, E. L., and Sellards, A. W.: Philippine J. Sc., Manila, 1913, **8**, 253.
15. Bockus, H. L.: See ref. 12, p. 658.

GLOMUS TUMOR*

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THE first pathologic report of glomus tumor, an entity of unknown etiology, was presented in 1924 by P. Masson.[1] A comprehensive analysis of 271 recorded cases by Beaton and Davis[2] appeared in 1941. A review of the literature since 1941 has been made and is discussed herein. The report of an additional case is presented.

Angioneuromyomata or glomus tumors were described by Masson[1] as

> "subungual tumors included in the cutis and without a capsule. The adjacent corpuscles of Vater-Pacini were flattened, indicating the cause of the painfulness of the tumor. The tumor was composed of a ball of contorted blood vessels, which were unequal in size and here and there showed wide lumina as seen in cavernomas. Striking were the thickness and unique composition of the walls of the vessels. As to the texture of the walls two types could be distinguished.
>
> "The first type showed a wide vascular lumen, the endothelium consisting of large cuboid cells and resting on a thin collagenous membrane. This membrane was surrounded by a layer of smooth muscle fibres, arranged circularly. Outside of this layer there were irregular, pale, muscle cells with ovoid nucleoles, which gradually passed over into epithelioid cells, these being polygonal, globular and nonfibrillary, the nuclei being spheric. These cells were densely piled in lobules and columns, much like those seen in certain epitheliomas or naevi. They were separated from each other by fine collagenous septa. These conglomerations of epithelioid cells, which were intertwined with dispersed muscle fibres, were situated in a connective tissue, rich in amyelinic nerve fibrils. The latter formed small fascicles, fusing with the epithelioid cells in such a way that the fibrils seemed to be processes of the cells.
>
> "The second type showed vessels with an irregular umen, its epithelium consisting of large cuboid cells too. But the blood vessels were so entangled that the epitheioid layers of their walls were inseparable from each other. Septa and columns of cells segregated the histologic constituents of adjacent vessels. Frequently these septa included innumerable fascicles of non-myelinated nerve fibrils, which sometimes formed real cords. Careful study of these revealed their intimate contact with the epithelioid cells. Hence the unquestionable nerves, embedded in the interstices of the tumorous vessels, not only were in close relation to them in a histologic sense, but seemed to have morphologic and genetic connections with the epithelioid cells of the walls, which in return were linked with muscle cells of any description.
>
> "As to the two different types of vessels, the first described ones were apparently the afferent vessels of the tumor, being branches of cutaneous arteries, while the vessels of the second type were their ramifications intertwined in a tumorous glomus, the so-called arterial angio-myoneuromata. Their specific structure, their benignity and localization suggested the assumption that they originated as hyperplasias of a special organic body."

The site of distribution of this subcutaneous tumor is usually the extremities. In women a preponderance has been found to occur in the nail beds, whereas in the male the location is less specific but is believed to be noted more generally in the forearms, knee region and legs.

The reported cases in English literature since 1941 include 5 of the arm (Jackson and Balkin,[3] Kaufman and Clark,[4] Slepyan,[5] German,[6] and Beattie[7]); 2 of the wrist (Kaufman and Clark,[4] and Cloward and Tilden[8]); 1 of the foot (Murray and Stout[9]); 5 of the leg (German,[6] Kaufman and Clark,[4] Hoffmann and Ghormley,[10] and Beattie[7]); 1 of the thumb (Jaeger and Kingry[11]); 4 of the finger (Loeb,[12] Rypins,[13] Scully,[14] and Loeb[15]); and 1 of the neck (Ottley[16]). Love[17] has discussed the diagnosis and treatment of glomus tumors.

The symptoms include an excruciatingly painful tumor frequently characterized by radiation of pain. It is felt that trauma plays a part in the etiology; however, since the lesion grows so slowly, any injury may easily be forgotten by the patient. The pain is frequently increased on exposure to cold. Perspiration in the adjacent area frequently accompanies the small, bluish tumor. Remarkable, however, is the exquisite tenderness of the affected region.

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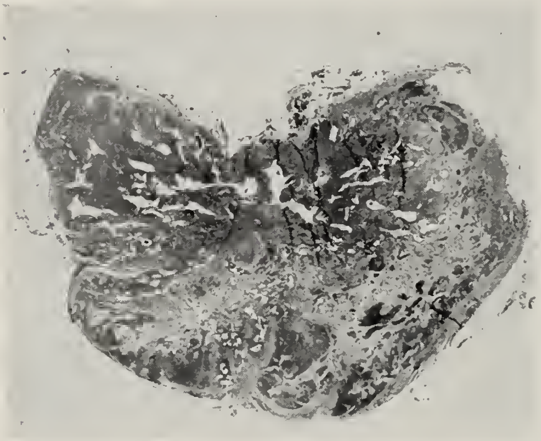

Fig. 1. Microscopic cross section of the entire tumor mass showing the encapsulation and interstitial fibrosis. The spaces are blood vessels which are surrounded by glomus cells. (× 8—neg. no. 97349—Army Institute of Pathology.)

Although the diagnosis is dependent upon laboratory confirmation, any lesion with seemingly disproportionate painfulness should immediately be suspected as glomus tumor.

In the differential diagnosis other superficial tumors, such as lipomas, sebaceous cysts, enlarged lymph nodes, epidermoid cysts, xanthomas, and ganglia, should be considered. None have the clinical characteristics of glomus tumor; however, a biopsy should always be made.

The clinical course of angioneuromyoma is that of a small, slow-growing, and increasingly painful tumor. As a result of the intensity of the pain, mental strain and depression often ensue.

Treatment consists solely of surgical extirpation. The operation is a simple one which relieves all complaints. There is no recurrence, and the prognosis is good. In only 1 reported instance has the tumor been infiltrative in character (Murray and Stout[9]).

Report of Case

A 68-year old orderly first noticed his tumor about 1903. It was located on the anterior aspect of the upper third of the left leg and at first was painless. However, it seemed to get tender after 1906 and had been moderately painful for 40 years. During the preceding 6 months it had become increasingly tender and caused the patient excruciating pain to touch. Intravenous sodium pentothal and gas were used for anesthesia because the area was so sensitive that it was very painful even when the skin was painted with an antiseptic agent. Even while going under anesthesia and showing no response to pin prick, the patient drew up his leg when the tumor was touched. Two days after operation, he patted the operative incision to show that the real pain had disappeared. At present he is without complaint.

Pathologic examination of this tissue by Dr. Oscar B. Hunter, Jr. revealed grossly a specimen measuring 2 cm. in diameter. It was grayish-white and fairly firm. On section it cut with some increase in resistance. The cut surface was somewhat irregular in appearance. Microscopically, sections through the tissue revealed a well defined tumor nodule which was completely surrounded by a loose fibrous connective tissue stroma (figure 1). The background of the tumor was a vascular one. Throughout the entire section there could be seen numerous vascular spaces lined by endothelial cells (figures 2 and 3). These vascular spaces varied from small capillaries to large dilated venules. In almost every one of these spaces there could be seen some blood corpuscles. Separating the vascular spaces and in many

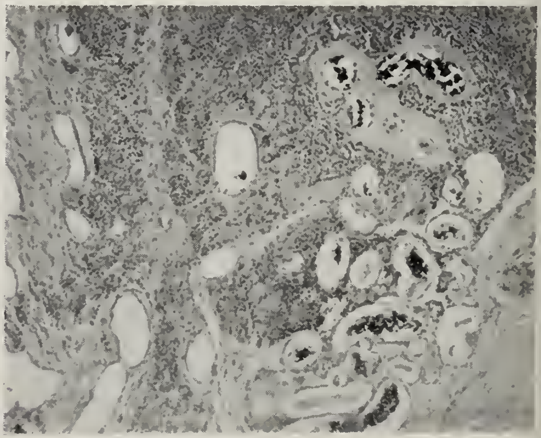

Fig. 2. Larger power of tumor. The cellular portions are masses of neuromyoepithelial (glomus) cells. (× 100—neg. no. 97348—A.I.P.)

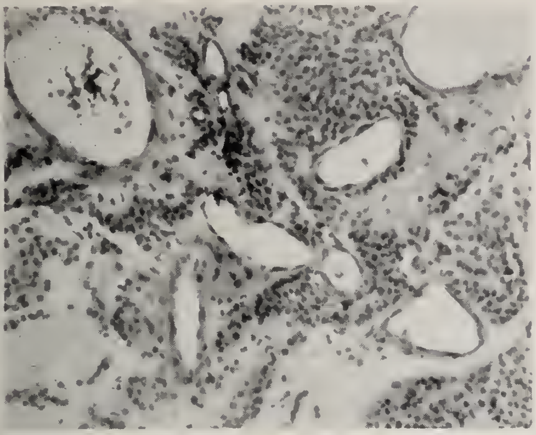

FIG. 3. High power of tumor showing relationship of tumor cells to vascular bed. There are no mitotic figures present. The stromal arrangement here is typical of these lesions. (× 205—neg. no. 97350—A.I.P.)

instances completely surrounding them were large masses of uniformly stained cells. These cells had moderately large basophilic nuclei. The nuclear material is granular and in some respects covered by a reticular nuclear meshwork. The cytoplasm of these cells was more frequently pink and granular, but on longitudinal sectioning they could be seen to contain fibrils. These fibrils were elongated and traversed in the cytoplasm, going around the nuclei. These clumps of cells surrounding and separating the vascular spaces were not infrequently interspersed by a hyaline matrix. This hyaline matrix was pink-staining and homogeneous, tending to be granular in some instances and fibrillar in others. This matrix contained nuclei similar to those already described, and in addition there were a few elongated fibrous connective tissue cells in between this material. In a number of instances there was some degeneration of the tumor, and the degeneration had taken on a myxomatous character. One other feature that was remarkable was the presence of a few scattered vessels which had markedly thickened walls. These walls were occasionally as thick as the diameter of the lumen and were hyalinized with a few nuclei.

This tumor is amazing in that it can produce such unbelievable pain. Note that in the case reported the patient under anesthesia did not respond to pin prick, but at the slightest touch in the area of the tumor raised his whole leg. That the complaint may be completely relieved with simple excision is another feature of interest.

BIBLIOGRAPHY

1. MASSON, P.: Lyon chirurg., 1924, **31**, 257.
2. BEATON, L. E., AND DAVIS, L.: Quart. Bull., Northwestern Univ. M. School, 1941, **15**, 245.
3. JACKSON, H., AND BALKIN, R.: Arch. Surg., 1946, **53**, 101.
4. KAUFMAN, L. R., AND CLARK, W. T.: Ann. Surg., 1941, **114**, 1102.
5. SLEPYAN, A. H.: Arch. Dermat. & Syph., 1944, **50**, 179.
6. GERMAN, W. M.: Am. J. Clin. Path., 1945, **15**, 199.
7. BEATTIE, W. M.: Lancet, 1945, **2**, 137.
8. CLOWARD, R. B., AND TILDEN, I. L.: Hawaii M. J., 1943, **2**, 299.
9. MURRAY, M. R., AND STOUT, A. P.: Am. J. Path., 1942, **18**, 183.
10. HOFFMANN, H. O. E., AND GHORMLEY, R. K.: Proc. Staff Meet., Mayo Clin., 1941, **16**, 13.
11. JAEGER, J. R., AND KINGRY, C. B.: Rocky Mountain M. J., 1941, **38**, 717.
12. LOEB, M. J.: J. Florida M. A.: 1943, **29**, 372.
13. RYPINS, E. L.: Am. J. Roentgenol., 1941, **46**, 667.
14. SCULLY, J. C.: J. Michigan M. Soc., 1943, **42**, 118.
15. LOEB, M. J.: Indust. Med., 1941, **10**, 208.
16. OTTLEY, C. M.: Brit. J. Surg., 1942, **29**, 387.
17. LOVE, J. G.: Proc. Staff Meet., Mayo Clin., 1944, **19**, 113.

President's Page

BACK THE CANCER CAMPAIGN!

The American Cancer Society, originally The American Society for the Control of Cancer, was established in April, 1922. It was reactivated on June 3, 1946. Dr. Frank Adair of New York, now President of the Society, is an outstanding medical authority in the cancer field. Local officers of the Washington unit of the American Cancer Society are: Dr. Harry H. Kerr, President; Eliot Wadsworth, Vice President; Dr. Calvin T. Klopp, Secretary; Mr. Frederick P. H. Siddons, Treasurer, and Mr. Ernest H. Edinger, Executive Director.

The objectives of the American Cancer Society are three-fold, namely, to assist every person who is suffering from a malignancy to obtain adequate care, to develop adequate facilities for the examination of individuals who wish to determine whether they have a malignancy, and to advance cancer research.

In an effort to realize these objectives, a campaign for funds will be undertaken in April. The Medical Society is coöperating by making available its auditorium for large group meetings. It is also represented on the governing board of the local cancer organization by Dr. Roger M. Choisser, Chairman of the Society's Committee on Cancer Control, and your President.

I am sure there is no health activity in this country today in which there is greater interest than in cancer control. I ask your whole-hearted response to the demands which may be made upon you in connection with the forthcoming drive. Your active participation will help more than you realize to make the cancer control program fully effective.

William P. Herbst Jr

Editorials

ALLIANCE PRODUCES NOTABLE RESULTS*

Wealth without health is of little value to the individual, the community or the nation. The medical profession, with a devotion surpassed by no other group, is dedicated to the care of our sick people and uses every bit of scientific knowledge available to make them well again. And through research and study, physicians all over the world are bringing to us each year new surgical technics, new remedies, new preventive procedures which are cutting down the incidence of disease and insuring an ever increasing percentage of cure for those who are ill.

The growth in public health services—Federal, state and local—has emphasized the importance and the increasing effectiveness of preventive measures and has helped "to narrow the spread between what we know and what we do." The steady decline in the incidence and the mortality of many common diseases bears witness to the successful efforts of both these groups.

But the work of public health physicians and the preventive activities of doctors in private practice will never be fully effective unless they have, not merely the compliance, but the active support and intelligent coöperation of the citizens of the community and their organizations. Layman, businessman, taxpayer backing is necessary to supply the tools, the personnel, the understanding and the money which will implement professional service and make it fully effective.

The United States Chamber of Commerce, with a supporting organization membership of about 2,600 chambers of commerce and trade associations, which in turn have an underlying membership of a million business and professional men, includes a health program as one of its accepted activities. This program is under the immediate supervision of the Health Advisory Council, made up of thirty-three outstanding men in the medical and public health fields, with a sprinkling of businessmen to round it out.

While recognizing that the major responsibility for national and community health rests on the medical profession and public and private health agencies, the Health Advisory Council is seeking to mobilize citizen support and coöperation for the community's medical and health instruments. Something over nine hundred chambers of commerce have undertaken definite health projects, almost invariably in coöperation with health departments, the medical profession and specialized health agencies. There is indubitable evidence that this support is welcome.

Not infrequently the local chamber of commerce has found it necessary to apply a stimulant to lagging public health service, but usually health officers have been ready to go as far and as fast as the community will give its intelligent interest and support. There is no sector of the public health field in which some chamber of commerce has not participated, and many of these organizations have developed extensive health programs. The Health Advisory Council of the National Chamber finds that this definite alliance between the professional health agencies and the businessmen of the community is producing notable results.

William K. Jackson
President, Chamber of Commerce
of the United States

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* This is the thirteenth in a series of guest editorials by distinguished physicians and laymen.

NEUROLOGICAL SURGERY IN WASHINGTON

Even as early as 1908, Harvey Cushing's reputation as a brain surgeon had traveled far and we may say that neurological surgery as a specialty had its birth in Baltimore where he began his pioneer work. He was followed at the Johns Hopkins Hospital by Walter Dandy, whose fame became almost as great as that of Cushing himself. Since Washington patients went to Baltimore there was little need for a brain surgeon here. Consequently, Washington got off to a slower start in the treatment of surgical diseases of the nervous system than many cities of comparable size.

During World War I, Dr. H. H. Kerr's interest in neurological surgery was aroused by his association with Harvey Cushing, and as a result, he took up neurosurgery along with general surgery on returning to Washington in 1918. Dr. Kerr made valuable contributions in the fields of both general surgery and neurosurgery. He is one of the pioneers in the surgery of the sympathetic nervous system and is a member of the Society of Neurological Surgeons. However, general surgery must have been his chief interest, because it is to this field that he has devoted most of his time.

Dr. John J. Shugrue was the first in Washington to limit his practice to neurosurgery. He was Professor of Neurosurgery at Georgetown University and chief of the neurosurgical service at the Emergency Hospital. He was an excellent neurologist and a competent neurosurgeon. He set a high standard for himself and demanded an equally high standard of practice of his colleagues. His influence was felt by those with whom he came in contact, but since he attended few meetings and wrote few papers he was not as well known outside of Washington as other men of his ability.

In the early days, surgery of the brain was concerned mainly with skull fractures and brain tumors. Although they still occupy an important place, they no longer make up a majority of the patients in neurosurgical practice. The frontiers have rapidly expanded and its physiologic applications are out-distancing the pathologic. The operation for tic douloureux was perfected by Frazier in the early 1920's. Section of the ninth nerve is equally effective in relieving glossopharyngeal neuralgia. The relief of pain in patients with carcinoma of the face, tongue and throat is gratifying after section of the fifth and ninth cranial nerves, and when the neck is involved a posterior rhizotomy is beneficial. Anterolateral cordotomy is equally effective in relieving pain in the pelvis and legs caused by carcinoma. Ménière's syndrome can be substantially relieved by section of the vestibular nerve. Surgery of the sympathetic was introduced by Hunter and Royal in 1926 as a method of treating spasticity and while this proved of no value, the interest aroused by their work has been far-reaching. Symptoms of peripheral vascular disease and causalgia are usually alleviated by sympathetic denervation of the extremities, often miraculously. In 1935 Adson operated upon the sympathetic in an effort to control hypertension, and, as the operation is being further applied, it seems to be giving gratifying results in relief of hypertensive symptoms.

Sciatic neuralgia became a neurosurgical problem in 1933 when Mixter and Barr described the protruded intervertebral disc as a clinical entity. Since then the operation for ruptured disc has become almost as standard a procedure for the neurosurgeon as appendectomy is to the general surgeon. The results have been excellent but there remain many cases of low back pain which are entirely orthopedic problems. Protruded disc in the cervical region is one cause of pain in the arm and hand, and this has to be differentiated from cervical arthritis and the anterior scalene syndrome. All may respond to appropriate neurosurgical intervention.

Prefrontal lobotomy, which was described by

Egas Moniz in 1935, was introduced into Washington the following year and further developed technically and in its applicability to the radical treatment of major psychiatric illness. It has led to renewed hope for the mentally ill patients and stimulated new interest in the frontal lobes. Washington has become the center for psychosurgery, and hardly a week goes by without visits from out-of-town physicians and operations upon out-of-town patients. More recently prefrontal lobotomy has been extended to the management of unbearable pain with encouraging results.

During the latter part of World War II, two neurosurgeons attempted to answer consultations throughout the city and nearby Virginia and Maryland, and to avoid as skillfully as possible what they were unable to cover. Word spread that the District of Columbia offered excellent opportunities, and we now have six well-qualified men who limit their practice to neurological surgery and a seventh is expected during the spring. Practicing physicians and their patients may therefore expect better and more prompt service, and the neurosurgeons will have more time to acquaint the physicians in the community with their work. It is hoped they will have an opportunity to carry on more investigative work which will not only be helpful to their patients but make Washington even more outstanding as a center for neurology and neurological surgery.

There are now neurosurgical services at the Children's, Doctors, Emergency, Gallinger, Georgetown and George Washington Hospitals. In addition to the local hospitals, there are active services at the Veterans Facility, Mt. Alto, and two service hospitals, Walter Reed and the National Naval Medical Center. The Gallinger Municipal Hospital, which is staffed by the Georgetown and George Washington Universities, offers a common meeting place for discussion of problems, and the Friday neurologic conference is attended by the neurologists and neurosurgeons of both schools. Although each man may have the last word in his own office and with his own referring physicians, on Friday at Gallinger he has the benefit of the advice and criticism of his colleagues. Pathologic specimens are examined following the conference, and the final diagnosis is written on cases at that time.

Georgetown University and George Washington University each has a modern 400-bed hospital under construction into which they expect to move this year. The George Washington Hospital has a special section assigned to neurology and neurological surgery with the necessary special equipment. The Children's Hospital has almost reached its quota in a drive for funds to build a new addition. A new 1500-bed medical center with Emergency, Episcopal and Garfield Hospitals participating appears to be more than a mere possibility.

It is our hope and belief that neurosurgery in Washington will continue to expand and develop, as it has done so rapidly in the last few years. That great progress has been made in other specialties is shown by the fact that so many District physicians have received formal recognition of their outstanding position in their respective fields. Dr. Joseph S. Wall was President of the American Academy of Pediatrics in 1945. Dr. Walter A. Bloedorn is President-elect of the Association of American Medical Colleges. Dr. Walter Freeman is the new President of the American Board of Psychiatry and Neurology, and Dr. Winfred Overholser is President-elect of the American Psychiatric Association. Dr. Custis Lee Hall is President of the American Chapter and Vice President of the International College of Surgeons. The Annual Assembly of the Medical Society of the District of Columbia ranks third or fourth in attendance among the state medical societies. The MEDICAL ANNALS has become a significant and widely read journal. Washington medicine need take a back seat to none, and the neurological surgeons in the District will do their part to make Washington outstanding.

JAMES W. WATTS, M.D.

GRADUATE MEDICAL EDUCATION IN WASHINGTON

In the spring of 1946, The George Washington University School of Medicine presented the first correlated series of postgraduate courses to be offered in Washington, at least in recent years. In this series, 171 physicians were enrolled for courses of instruction ranging from one to nine weeks. The great majority of these doctors came to Washington from other cities, although many local physicians were included.

Following this series, the W. K. Kellogg Foundation renewed and enlarged its grant to the School for graduate medical education. The second series of courses is now in progress, similar to the program offered in 1946, although no courses are included lasting longer than five weeks. A distinctive and very gratifying feature of this program is the fact that one hundred and two prominent physicians from other cities have accepted invitations to appear as members of the "Guest Faculty." Included are some of the most distinguished names in American medicine.

The current series of courses includes instruction in most of the fields of medical practice. The general practitioner, internist, general surgeon, psychiatrist, pediatrician, neurologist, obstetrician, gynecologist, ophthalmologist, cardiologist, anesthetist and others can each obtain at least one week's intensive instruction.

Graduate courses in the basic medical sciences are offered this year for the first time, in response to the need for such instruction to supplement clinical training in the hospitals. Two courses are offered, one for surgeons and one for men in the medical specialties. The curriculum includes anatomy, physiology, biochemistry, pharmacology, bacteriology, pathology, radiology and radiation physics. Members of the clinical staff participate with the basic science faculty in all sessions and the clinical application of the fundamental sciences is stressed. Currently more than a hundred physicians are enrolled in these two part-time courses. Residents from 16 hospitals in the metropolitan area are included, as well as a number of practicing physicians. It is hoped that, by affiliating with the University for this instruction, more hospitals in the area may become approved for residency training in the specialties.

With the opening of the new George Washington University Hospital, a large number of new opportunities for specialty training will become available here.

In the light of these observations it is well to consider the future of graduate medical education in Washington.

It should be apparent to all that Washington is a logical city for an extensive program of medical education at all levels. The great Federal establishments here offer unusual opportunities for research. The medical libraries in Washington are the best in the world. The Army Institute of Pathology has an almost unlimited wealth of material. With the contemplated expansion of most of the hospitals in the city, excellent opportunities will be provided for clinical research and for teaching. There are large numbers of well-trained specialists in Washington who can be depended on to provide sound instruction.

At the same time, the demand for such training is possibly focused on Washington more than on any other city. With the great medical institutions of Europe largely destroyed by war, the world is turning to America for help in the training of young physicians. Because Washington is the political center of the continent, many of these men begin their search for graduate training in Washington, turning to other cities only if they cannot find the opportunity here. This demand is in addition to the usual one common to all large cities.

Washington is therefore a city of great opportunity in medical education. How the need will be satisfied depends largely on the leadership which the Universities can offer. Only a small start has been made to date. The planning must be large and bold if the challenge is to be met.

Thomas M. Peery, M.D.
Director of Postgraduate Instruction,
George Washington University School of Medicine

THE DAVIDSON LECTURE

The Ninth Davidson Lecture will be presented at the first scientific meeting in October. With the return to private practice of most of our service physicians, it is expected that competition for this biennial award will be unusually keen.

The Davidson Lecture was established in 1929 to commemorate the outstanding service rendered to the medical profession in the District of Columbia by Dr. Edward Young Davidson. The selection of a lecturer was placed on a competetive basis in 1936 in the hope that it would stimulate research and performance of a high order. That this goal has been achieved can be attested by the high caliber of all the papers which have been selected for presentation up to this time. To acquaint the younger members of the Society and newcomers to Washington with the scope of the material used as subject matter in the past, there are listed below the titles of the last five lectures and the dinstinguished authors who were honored for their excellent papers:

1937—"Factors in the Production and Treatment of Shock: An Experimental Study," Harry A. Davis, M.D.
1939—"The Surgical Treatment of Mental Disorders," Walter Freeman, M.D.
1941—"Recent Advances in Diseases of the Pancreas," Robert J. Coffey, M.D.
1943—"Frontiers of Multiple Sclerosis," Walter Freeman, M.D.
1945—"The Role of the Small Vessels and Nerves of the Heart in Heart Failure, Coronary Artery Thrombosis and Cardiac Pain," Joseph T. Roberts, M.D.

The following rules govern the choice of the Davidson Lecturer:

"The selection of the Davidson Lecturer shall be on the basis of competition, the winning essay to be selected by a subcommittee consisting of five (5) members of the Executive Board appointed by the Chairman. No member can serve on the committee who may desire to compete.

"The competition shall be thrown open to physicians or other scientists working in the District of Columbia.

"The essays to be submitted must bear no indication of the author's identity, being signed by a nom de plume. The identification of the author must be in a sealed envelope bearing on its surface the same nom de plume. No essay may be submitted that has been published.

"Essays should be submitted to the Secretary of the Medical Society of the District of Columbia not later than July 1 of odd numbered years.

"In case no essay is found worthy of an award, the subcommittee shall declare no award; the lecturer then to be selected by the full Executive Board."

All essays must be in the hands of the Secretary of the Society not later than July 1, 1947; no manuscripts will be accepted after that date.

It is hoped that members will publicize this announcement as fully as possible since the competition is open to physicians and scientists in allied fields who are members or non-members of the Society.

In and Out of Focus

BY THE OBSERVER

St. Elizabeths' Transfer Opposed

The proposal made by the District Budget Officer, Walter L. Fowler, that St. Elizabeths Hospital "be transferred to the Government of the District of Columbia for a master hospital and welfare center" has evoked a storm of protest in medical circles. Psychiatrists, particularly, are deeply concerned because St. Elizabeths has always been and still remains one of the finest mental institutions in the world. Medical men come to Washington from all parts of the world to observe at first hand the application of the latest in psychiatric treatment. It is small wonder then that psychiatrists here and elsewhere are greatly perturbed.

Prompt action in regard to this matter was taken by the Washington Metropolitan Health Council. A special committee was appointed consisting of Dr. Robert H. Groh and Mr. G. Howland Shaw for the purpose of studying Mr. Fowler's proposal. The committee was requested to submit its recommendations to the Council's Executive Committee. In its report the special committee pointed out that Mr. Fowler had not consulted "any of the responsible and technically competent persons most directly involved," and that his report was confined entirely to the fiscal aspects of the proposed transfer. But, the special committee says, even from this point of view Mr. Fowler's case is not convincing.

> "The District, at present, has, in St. Elizabeths," the special committee observes, "an excellent hospital at its disposal for the care of its mentally ill. This hospital has been constructed and all capital costs and cost of replacements have been borne by the Federal Government. These costs were met in times when materials, labor, and over-all costs of building were at a far lower level than today so that any new buildings or replacements from now on would be at much higher levels. At present the District pays only its proportionate share of total operating expenses. These expenses may seem high. However, a few figures will show that the District is now receiving a nationally recognized high standard of care for its mentally ill at a per diem cost which is just half of what the District charges per day in its own comparable institution. Specifically, the District is asked to pay $3.55 a day for the care of patients at St. Elizabeths Hospital, while the District is asking $7.50 a day from the patients at Gallinger Hospital. In 1942, the per diem charge was $1.90 a day for the care of patients at St. Elizabeths Hospital. At that time, an unofficial figure shows that the District was asking $3.00 to $3.50 a day for the care of patients at Gallinger Hospital. These figures seem particularly significant to your Committee and lead us to believe that if Mr. Fowler's purpose of economy is to be achieved, it can only be done by reducing the quality of care given to the patients.
>
> "This discrepancy is the more significant when consideration is given to the fact that the quality of services in the two Federal institutions, the St. Elizabeths Hospital and the National Training School for Boys to which Mr. Fowler specifically refers, is on a high level; whereas, the level of service rendered at the various District institutions is notoriously low and inadequate.
>
> "Mr. Fowler's proposal apparently stems from the President's reorganization plan number 3 of June 1946. Under that plan, certain responsibilities were taken from the Superintendent of St. Elizabeths Hospital on the grounds that growth in population of the District of Columbia and the wartime expansion of the armed forces made the facilities of that Hospital inadequate. It was, therefore, directed that the Navy Department discontinue the use of St. Elizabeths Hospital. The functions of the Hospital with respect to the insane of the Coast Guard were also abolished. Mr. Fowler makes a point that this reorganization plan presumably indicates that St. Elizabeths has lost its usefulness for Federal purposes. However, in his own report, Mr. Fowler mentions the number of Federal patients still at St. Elizabeths Hospital for whom the Federal Government has responsibility. This group of patients totaled in 1946 2,032 and an estimated 1,420 in 1947. This Committee feels, along with other individuals, that the Capital City of the Nation will always need a Federal institution to take care of Federal cases."

"Mr. Fowler proposed that the Hospital, if taken over by the District, should accommodate, besides mental patients, the aged, the feeble-minded, and delinquent children. Any such arbitrary lumping together of these groups is entirely contrary to accepted standards of care. This fact was recognized even in 1924 when a tract of land was purchased and the District Training School shortly thereafter opened at Laurel, and the feeble-minded who had, up to that time, been accommodated in St. Elizabeths Hospital, were removed. Any effort to adapt the land on which St. Elizabeths Hospital is built to the diverse uses Mr. Fowler proposes, besides being expensive, would be doomed to failure. The tract of 360 acres would be inadequate for the recreational and other facilities needed by an institution for the feeble-minded or for children and, in any event, the nature of the land does not permit of any appreciable new utilization. A Public Buildings Administration unofficial estimate was that 40 per cent of the 360 acres is in deep cuts and ravines, unsuitable for building purposes and, therefore, too, unsuitable for the necessary recreation ground space. When it comes to the possibility of adapting the existing buildings at St. Elizabeths, the picture is just as unsatisfactory. Contrary to Mr. Fowler's statement, many of the buildings at St. Elizabeths are old, not fireproof, and have served their usefulness. They were originally built for the care of psychotic individuals and are unadaptable to the accommodation of the non-psychotic, whether these be aged, feeble-minded, or children, delinquent or non-delinquent. The thought which Mr. Fowler expresses on page 10 of his report that by taking over St. Elizabeths, the District could avoid a building program to take care of its institutional needs is, therefore, entirely illusory.

"The District already has a considerable investment at the home for the aged and at the District Training School at Laurel. Mr. Fowler's proposal would apparently involve discarding this investment. It would also mean the complete abandonment of the carefully thought out plans of the Board of Public Welfare for a Children's Center to take the place of the existing unsatisfactory facilities for the care of delinquent children and to enlarge the facilities now available for the feeble-minded.

"Mr. Fowler seems to look on all the aged as a homogeneous group and proposed that all the patients in St. Elizabeths who are suffering, for example, from senile psychosis should be placed in the same wards as the elderly patients now domiciled at Blue Plains. The idea of mixing psychotic and non-psychotic, whether the latter are aged persons, the feeble-minded or children, is repugnant from every point of view and contrary to all modern psychiatric trends.

"St. Elizabeths Hospital is internationally recognized for its high standards of care to the mentally ill. It is also looked upon as an institution unsurpassed in training facilities for groups interested in all phases of psychiatric orientation. Over the years, St. Elizabeths has achieved an outstanding and enviable record in scientific research. Any proposal which involves a reduction in these achievements and standards would be a blow below the belt to American psychiatry. Indeed, so seriously is this aspect considered that a communication from the President of the American Board of Psychiatry and Neurology tells us that if such a proposal as Mr. Fowler's is carried out, the American Board would require reinspection of St. Elizabeths Hospital to evaluate its standards of teaching in psychiatry. If the District of Columbia assumes the control of St. Elizabeths Hospital, there is reason to believe that the high standards would be reduced. The record of the District of Columbia in maintaining its institutions encourages nothing but pessimism in this respect. Mr. Fowler's report makes mention of this very fact at the bottom of page 7 and the top of page 8. Any falling off of the reputation and standards of the Hospital would inevitably lead to a loss of its present highly qualified personnel and to an eventual deterioration of the personnel, as a whole.

"The problems of administering a 'Master Hospital and Welfare Center' with the most varied population presumably under two departments of the District Government, health and welfare, seem to your Committee to be of such a complex character as to constitute a serious objection to the whole plan.

"This Committee is very clear in its judgment that Mr. Fowler's plan for a 'Master Hospital and Welfare Center' is neither desirable nor feasible from any point of view."

The Council's Executive Committee unanimously approved this report and voted "that a delegation be asked to wait upon the Commissioners." Shortly thereafter, the Medical Society's Subcommittee on Mental Health took a strong position in opposition to the transfer of St. Elizabeths. Both the Society's Committee on Public Health and Executive Board concurred in the Subcommittee's action.

It is to be hoped that the public will support the position taken by these bodies, largely composed of physicians. Maintaining high standards at St. Elizabeths is largely a medical problem, and one which cannot be evaluated by financial experts alone. Even if this were not true, the experts have not come up with a more economical method of operation.

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Press Relations

Although the Medical Society's relations with Washington newspapers have been most satisfactory, there is still room for considerable improvement. This is recognized by physicians and newspapers alike.

Not long ago your Observer received a call from the city editor of one of Washington's large dailies. The editor had recently attended the American Press Institute at Columbia University. Among the subjects discussed was the coverage of medical news. The editor was impressed with what he heard, and came back with many ideas which he talked over at length with your Observer. It was finally agreed that it would be desirable to arrange a conference at which this matter could be discussed at some length.

The conference, which was held shortly thereafter, was attended by the two city editors and three reporters who usually cover medical news, Dr. Walter R. Stokes, Chairman of the Society's Committee on Public Relations, and your Observer. All agreed upon the necessity of improving the methods by which the Society supplies information to the press with regard to scientific matters. It was proposed that a panel of physicians be appointed, a regular appointee and an alternate in each specialty, whom reporters covering medical news would call and verify scientific information before it appears in their newspapers. Names of physicians would, of course, not be used. However, a list of physicians on the panel would be provided each newspaper so that there would be no lost time in verifying facts. Where subjects are of such a nature that none of the experts could be of assistance, Dr. Stokes would be called. Inquiries with respect to the social and economic aspects of medicine, it was agreed, should be directed to the Secretary of the Society.

This proposal was most enthusiastically received, and referred to the Executive Board, which gave its approval. The Board instructed the Chairman, Dr. Stokes, to proceed with the development of the plan, the first step being to submit the names of physicians to be appointed to the panel. At the time this is written, Dr. Stokes has completed the panel, which now must be presented to the Executive Board for confirmation.

In addition to the above arrangement, it was agreed that where a physician has done original research work, or has rendered unique service to a patient, there is no objection to his name being used in the press. In fact, it is to be desired that recognition be given him, as it can only reflect credit on the medical profession as a whole. From the newspaper's point of view this is legitimate news and editors cannot understand why there should be any objections raised, providing the reporting is accurate. However, it was suggested that if the physician had any official connection with an institution, this fact should be stated. In any event, the type of practice in which he is engaged should be omitted.

Your Observer feels certain that our members will agree that the proposals agreed upon are a forward step in press relations, which bodes well not only for physicians of this community but for the public.

A word should be said here about the splendid attitude of editors and reporters who participated in the conference. They were coöperative and understanding. Most of our members are acquainted with the reporters who regularly cover medical news, Harold B. Rogers of the *Evening Star*, Gerald G. Gross of the *Washington Post*, and Edwin D. Neff of the *Washington Times-Herald*. Few newspapers can boast of abler reporters or better informed ones where medicine is concerned. Benjamin W. Gilbert of the *Post* and I. William Hill of the *Star* were largely responsible for the conference being held.

". . . and Both Start with P"

Those who attended the joint meeting of The Medical Society of the District of Columbia and the District of Columbia Pharmaceutical Association held on January 29, 1947, will long remember it as a most stimulating session. For it was one of those rare occasions when both the subject matter and the speakers are happily chosen. This was particularly true of the principal speaker, Dr. Louis A. M. Krause, Associate Professor of Medicine at the University of Maryland, and his subject. Dr. Krause is a vivid personality, an outstanding scientist, and a cultured gentleman. In your Observer's opinion, he surpasses any other physician in this country on the rostrum. His eloquence was such on the night of the recent meeting that not a person in the large audience left the auditorium until he was through. One can only envy medical students who come under his tutelage, for they will not only learn something about medicine, but will also be given a cultural background.

Your Observer has learned from a number of sources the high regard in which Dr. Krause is held by those with whom he served in the armed forces. Here he also displayed his superior qualities as a physician and a scholar. On a number of occasions he lectured to his junior officers on subjects other than those related to medicine, and did so in such able fashion as to evoke enthusiastic praise.

Following Dr. Krause's address on the broad topic, "Current Trends in Therapeutics," Dr. Worth B. Daniels, Clinical Professor of Medicine at Georgetown University School of Medicine, and Dr. Robert P. Herwick, Director of the Medical Division, Food and Drug Administration of Washington, took up the discussion.

When Dr. Daniels was called upon, he said he defied anyone to discuss Dr. Krause's presentation. However, it is Dr. Daniels' observations with which your Observer wishes to concern himself here. Dr. Daniels, who is well known to all Washington physicians, made some very pertinent remarks. Speaking of the progress in medicine, with particular reference to new drugs, he said:

> The medical life of most of us has spanned the period of the greatest revolution in therapeutics in the history of medicine. As one glances back through the books on therapeutics of 25 years ago, only a few materials used still hold places of importance. Morphine, of course, comes first and though challenged by demerol and other pharmaceuticals, maintains its place as an indispensable. Salvarsan is being replaced by penicillin, quinine by atabrine, choraquine, pentaquin and other more effective antimalarials. Digitalis, emetine, pituitrin, ergot, adrenalin, iron and thyroid extract still stand unchallenged, though some of these have been changed by the pharmaceutical chemists into purer and more efficient forms."

Unfortunately, Dr. Daniels points out, not the best use has been made of the valuable drugs which have been discovered in recent years, for, he continues:

> "Though we have more drugs and know more about them, our intelligence and our critique in their use leave much to be desired. There is a tremendous chasm between the knowledge accumulated by the pharmacologists and that applied by the practitioner. We look down our noses at the practitioner of the past, who in his shotgun prescription hoped that at least one of its myriad of ingredients might act beneficially. And yet too many practitioners and drug manufacturers are equally and less excusably empirical. We learn that extracts of liver help macrocytic anemia and we have known for generations that iron improves the patient with iron deficiency anemia. Presto! Every manufacturer leaps on the market with a capsule, ampule, vial, powder or concoction, each with a different and less pronounceable name and each containing too little liver to obtain maximal response in pernicious anemia and often too little iron to cure iron deficiency anemia. And now before the ink is dry on Spies' publications on folic acid in macrocytic anemia, a manufacturer has mixed it with iron and marketed it with a bastard name.
>
> "Again when powerful new drugs, such as the sulfonamides, are discovered they are soon mixed with chewing gum, nose drops, suppositories, lozenges, etc., in quantities sufficient to sensitize and insufficient to cure. This is not the fault of the manufacturer alone. The practitioner must inform himself by the study of source material of the basic actions of new drugs and use them intelligently in remediable diseases rather than hopefully

andunreasoningly in pip because he's found them good in pellagra and both start with a P. It was formerly said that if the patient was not better after 48 hours on sulfonamide medication the physician did a physical examination. This is becoming fast true of penicillin and other antibiotics. These powerful and expensive materials are being prescribed in troches, nose drops, lozenges, eyewashes, mouth lotions and in a myriad of ways for the common cold and other diseases in which they are utterly worthless, and given in inadequate dosage by mouth in illnesses where they could be genuinely beneficial.

"Evidence is accumulating that disease organisms become 'fast' or resistant to penicillin. The best way to create 'fastness' in an organism is to strike it with less than maximal concentrations of an antibiotic. Rammelkamp in the earliest studies on penicillin showed this to be especially true with the staphylococcus aureus. Unfortunately, penicillin is begun by many practitioners before any attempt has been made to obtain material for culture. This is complete empiricism, since pneumonia may be due to the Friedlander's bacillus or to the Bacillus tularaeuse, both of which respond to streptomycin and not to penicillin. With our present antibiotics and new ones undoubtedly on the way, bacteriologic study in each patient with an infection is more important than ever before.

"I am trying to plead that the practitioner first make an accurate diagnosis and an etiologic one before beginning treatment and that he keep himself informed by the study of source material, not advertisements, of the indications for and limitations of the various available drugs. I am pleading too that manufacturers avoid making and marketing mixtures of drugs under bizarre and difficult trade names and that they use their expensive advertising space to disseminate knowledge—not conjecture."

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Is Indoctrination Necessary?

Readers of this column will recall that some months ago—in April, 1946, to be exact—your Observer described an indoctrination program for applicants for membership in the Los Angeles County Medical Association. The program called for mandatory attendance at a series of six lectures to be given each month, to be followed by an examination to discover whether applicants had really gained anything from the lectures. Subjects discussed were Medical Organization, Health Insurance, Medical Public Relations, Medical Ethics, Medical Education and Medical Economics, and Medical Malpractice. An indoctrination committee and six subcommittees arranged the lectures.

There was considerable skepticism in the beginning as to how the lectures would be accepted, it being fully expected that physicians would protest the requirement that they attend. However, the reverse has proved to be true. In fact, considerable enthusiasm has been shown by applicants.

At the time your Observer first commented on this program, he reported having called it to the attention of the Society's Executive Board. The Board decided that, for the time being, it was not practical to undertake a similar program in Washington. However, the matter was referred to the Membership Committee for its consideration. While no action has been taken by the Committee, President Herbst, at a recent meeting of the Board, said he had learned more about the indoctrination program and felt that it should be given a trial by our Society. The Board thereupon instructed the Secretary to communicate again with the Committee, requesting its views.

Knowledge of the subjects discussed in the Los Angeles indoctrination program is exceedingly important to physicians. It would not only benefit them individually, but medical organizations to which they belong would be strengthened. Take the matter of ethics, as an example. The ignorance of many physicians with respect to this subject is appalling. Medical ethics are usually discussed in medical school, but it is apparent that the discussion does not sink deep into the consciousness of medical students. Most physicians, of course, have a general idea as to the conduct expected of them, but there are many phases of ethics with which they are unacquainted. What is needed, it would seem, is a clear, understandable presentation of the subject of ethics as they apply to everyday practice. At the same time there might be a discussion of the traditions of medicine in the community, because these are linked very closely to the matter of ethics.

From your Observer's viewpoint, an indoctrination course, even if it were to consist entirely of lectures on ethics in everyday practice, would be worth while. It would be applying the preventive principle to a very important phase of medicine. Certainly much misunderstanding and ill feeling could be avoided, especially among younger physicians, if the rules laid down for their conduct were thoroughly understood. And patients, too, would benefit by the adherence of physicians to rules governing professional behavior.

It is to be hoped that our Society will adopt an indoctrination program suitable to its own needs and will not be too long in doing so.

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Postwar Pressure

Those of us who remained on the home front during the War looked forward in happy anticipation to the end of the conflict, not only because we wished the terrible war to end so that our loved ones would return home, but to be relieved of the pressure under which many of us had labored. Fortunately, there finally came a time when our boys turned homeward; however, to most individuals in positions of responsibility, the postwar months have not brought the relief expected. In fact, your Observer has talked to many men, among them physicians, and he finds they are not only fully occupied but concerned because there is no slackening in the pace of their existence.

A few weeks ago your Observer received a letter from a medical society executive, a portion of which points up the foregoing statements. "I am overwhelmed with detail," he writes. "Although my staff has recently been expanded, each month I seem to be burdened with more detail. Every day I get an average of thirty-five personal letters requiring a personal reply. The time this requires leaves me little opportunity to do other and bigger things I want to do. The constant pressure of other detail that passes over my desk makes me wonder if I am not deficient in executive capacity."

Your Observer wrote this executive in reply, "In all the years I have been engaged in executive work, I have never been harassed by details as I am now. While I do not have to answer thirty-five letters a day, I have more than that number of telephone calls (besides an immense amount of paper work). The only solution, it seems to me, lies in employing abler assistants and departmentalizing one's responsibilities."

Since this exchange of correspondence, your Observer has had an opportunity to reflect upon the situation, and as a result has come to several conclusions. To begin with, he notes that people are more restless than during the War, and therefore not content unless they are constantly active. They look about avidly for something to do. It has inevitably followed that causes, campaigns, and organizations have multiplied and that increasing demands are made upon individuals. Under these circumstances, it is not surprising that persons whom one employs, particularly those of the so-called white collar class, are jittery. There are, of course, other factors which are responsible for this state, of which uncertainty about the future and abnormal economic conditions most certainly stand out.

Considering that we are in the midst of a boom with employment at an all-time high, this, to say the least, is a paradoxical situation. As every employer knows, there are very few individuals of ability looking for positions these days. By and large those who seek employment are inferior to those available before the War. Saddled with incompetents, small wonder that employers—and that includes physicians—are at their wits' end. They, too, have "nerves," because they are of necessity buried in details and carry on efficiently only with the greatest difficulty.

What can one do about this state of affairs? Here, at least, are a few suggestions to both employer and employee, which seem plausible to your Observer. First, to refuse to be a joiner. There is a limit to the number of organizations to which an individual should belong. Your Observer has felt that the limit has long since been passed for him. The second is to restrict one's activities. That has a relation to the first, but goes beyond it. Most of us take on many more responsibilities than we should. If employees would keep this in mind where their "outside" activities are concerned they would find life much less hectic. As to the executive or the physician in the employer-employee relationship, it is far better to employ fewer workers, but capable ones. The cost will be higher, but in the long run there will be a saving. And finally, we all need to develop a philosophy which concerns itself not too much about the future. In other words, we should live in the present, and focus our entire attention, within reasonable limits, upon each day's problems. All these things will tend to slow up the pace of living with consequent benefits for everyone.

Anyone who views the current scene objectively can come to only one conclusion: We as a people are in a sad state psychologically which only we as individuals can remedy.

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An Uneducated Generation?

There would be cause for serious concern if the younger generation did not feel misunderstood by their elders. It has always been so, and it perhaps always will be. As your Observer said in last month's MEDICAL ANNALS, he has heard criticism of older physicians by younger ones ever since he can remember. But older practitioners, as he has also observed, are inclined to be intolerant of their juniors. Whatever may be one's views in this matter, one cannot escape the conclusion that our youth are pretty much what their elders have made them.

If this be true, oldsters must have many regrets when they look at their handiwork. From the standpoint of education, for example, there are such glaring deficiencies as to be depressing. Let us take the type of people usually employed in the doctor's office. Your Observer has had an opportunity to learn something about them, for one of the services rendered to the Society's membership is the listing of secretaries, technicians, and office assistants seeking employment with physicians. What was to him in the beginning rather astounding, but has now become commonplace, is the lack of cultural background in this group. When asked what they read, the reply is usually evasive, or one learns it is of a very trivial nature. Apparently during their school years they read little literature of importance, and what they read they did not absorb. At least they received no inspiration which led to reading worthwhile books following their school years. Of course, such individuals do not realize why they are not first-rate in their chosen work.

Essential though cultural background is, these individuals might ordinarily "get by" if it were not for their ignorance of simple grammatical usage. A surprising number of them cannot even spell ordinary words correctly. All in all, their deficiencies are, to say the least, discouraging to the employer who seeks intelligent assistants.

This state of affairs is, of course, not confined to so-called white collar workers. In fact, a public official and a doctor of medicine, who has some knowledge of the cultural background of physicians, said the other day that the average physician reveals only too plainly the inadequacy of his early training. Evidence of this fact is his inability to write clearly and grammatically.

Lest someone charge that this is only one man's opinion, or at best represents the views of a small minority, your Observer hastens to say that he has discussed this subject with a number of educators. The conclusion is always the same. Colonel Amos R. Koontz, M.D., A.U.S., writing on the subject "Are Doctors Educated?" in the January, 1947 issue of *The Military Surgeon*, is among those taking a dim view of the physician's cultural background. He writes:

> "Can it be that the majority of doctors do not care for the niceties of language? It is obvious that some of them consider their odd pronunciations 'fancy' or 'high toned,' (really smacking of pseudo-erudition), not realizing that one of the earmarks of culture is correctness of speech. It makes one wonder whether the entrance requirements for medical school are high enough. Certainly, at the present time, too much attention is paid to so-called 'pre-medical' subjects and not enough to the cultural things that go with a general education. A physician, in order to be a leader, such as he has always been, should have a good general education first, and at least know how to speak and use his language before he puts too much time on subjects dealing directly with his profession. Too many students, ambitious to be doctors quickly, have the feeling that only science courses are 'pre-medical' courses. This, of course, is entirely erroneous and such an attitude tends to make a trade, rather than a profession, out of medicine. I consider the term 'pre-medical' an abomination—everything, prior to entry into medical school, that goes to make a doctor, from his birth on, is *really* pre-medical. If English and other subjects, such as History, Philosophy, Modern Languages etc. are not pre-medical subjects, then I have the wrong conception of the profession and have been brought up in the wrong school; for I believe that the prospective doctor should be an educated gentleman before he undertakes the study of medicine."

Educators, or at least most of them, take pride in the present educational system. However, there is something out-of-joint somewhere. Much of the difficulty, of course, lies in early days of the individual's training, that is, in elementary schools. What we need to do, apparently, is return to the teaching of fundamentals—instruction in the Three R's if you please. Only by building on a sound foundation can we develop a cultured generation, persons interested in more worthwhile avocations than cursory newspaper reading with emphasis on comics, attending movies, and listening to the radio.

Curb on Sale of Barbiturates Advocated

Agitation for the enactment of drastic legislation to curb the sale of barbiturates in the District of Columbia has been a source of concern to physicians who see the dangers inherent in too restrictive regulations. At a recent meeting of the Interprofessional Conference,* ways and means of dealing with this problem were considered. Representatives of the District of Columbia Pharmaceutical Association urged support for its Proposed Uniform State Barbiturate Act which would regulate the handling, sale, and distribution of barbiturates. This legislative proposal, it was argued, would meet the approval of both physicians and pharmacists. The Conference examined the proposed bill section by section, making several changes in it. As amended, it is published elsewhere in this issue of MEDICAL ANNALS.

It is to be hoped that the proposed bill will be approved by the Medical Society and its passage urged by the Congress. This legislation will in no way hamper the physician in the treatment of his patient, but it will prevent patients from imposing upon him or using barbiturates to the point where their health is endangered.

It is quite apparent that some physicians have not exercised good judgment in prescribing barbiturates. Under "Correspondence" in this number of the ANNALS will be found a letter from Rohda J. Milliken, Director of the Woman's Bureau of the Washington Metropolitan Police Department. This communication discloses that recently three physicians prescribed an excessive amount of nembutal, barbital, and similar sedatives on three successive days to a woman who had been drinking without knowing anything about her. Upon inquiry it was learned that none of the doctors had known the woman as a regular patient, nor did they know that she was going to other physicians. This is the sort of thing that can only lead to injurious restrictive legislation.

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* This organization is composed of representatives of the medical, dental, nursing, pharmaceutical, and hospital organizations in the District of Columbia. Mutual problems are discussed by the Conference, and where there is unanimous agreement, action is taken. Matters of importance are frequently referred to participating organizations for their views.

At a meeting held on January 31, 1947, the following officers were elected for the ensuing year: Mr. Paul Briggs, *Chairman;* Dr. Karl Wood, *Vice Chairman;* and Miss Edith M. Beattie, *Secretary-Treasurer.*

It is suggested to members that they familiarize themselves with the proposed legislation, and express any views which they have on the subject to the Society's Committee on Public Policy, which will in time consider this matter. It is very important that no law be enacted which will in any way make it impossible for physicians to do all that is necessary for patients who come under their care. However, some regulations with respect to barbiturates are necessary, and the bill offered by the District of Columbia Pharmaceutical Association would seem to be the answer.

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The $100,000,000 Question

Would unlimited funds for research speed up the discovery of a cure for cancer? That, according to a Washington news commentator, is the $100,000,000 question which was before the Seventy-ninth Congress, and is now being considered by the Eightieth. Senator Pepper of Florida has reintroduced his bill, making this sum available for research purposes.

What do experts in this field think about the Senator's bill? Dr. Roscoe R. Spencer, Director of the National Cancer Institute, is apparently convinced that millions of American lives could be saved if more money were available to educate the public in regard to cancer, and to expand treatment as well as research facilities.

Views of the United States Public Health Service in respect to this legislation, are: (1) Federal action on a scale much larger than heretofore is urgently needed; (2) increased Federal support is necessary, not only for research into the cause and means of control of cancer, but also for assisting states and local communities in applying more efficiently the knowledge that already has been acquired; (3) this stepped-up program, regardless of its magnitude, should be placed under the jurisdiction of the Public Health Service rather than in a new organization that might be created outside the Government.

Dr. Thomas Parran, Surgeon General of the Health Service, makes a point of the fact that money alone will not do the job. "Besides more funds," he says, "we need more well-trained research personnel and, most important of all, we need the spark of brilliance in research. Money won't buy this, overnight, but it takes money to train the personnel that we need. Actually, the outlook for cancer research and control in the United States looks more encouraging today than it has at any time."

When it is suggested that if enough scientific brains are put to work on the problem, we may be rewarded with the success which attended the scientists assigned to atomic energy, Dr. Parran says: "The cancer problem today and the atomic bomb situations in 1941 are quite dissimilar. For instance, in 1941, the fundamental knowledge regarding atomic fission was much more complete than is our current knowledge of cancer prevention. Intensified studies, broadly based to find the cause and cure of cancer, probably will be most fruitful if directed towards the fundamental problems of cellular life, the interaction of groups of cells and organ systems in this most complicated of all chemical structures, man himself."

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Women Medics

Reports from leading medical schools reveal that more women are being trained in medicine than ever before. Enrollment runs ten to sixteen per cent, which is the highest on record. Despite the increase in women medical students, *Time*, the weekly news magazine reports that "going is still tough." "Women medicos," *Time* says, "find it hard to get internships (most hospitals lack separate living quarters for female internes), jobs as resident doctors, and male patients. For many, only two kinds of doctoring are open: (1) obstetrics, (2) pediatrics."

The other day, a copy of *Philadelphia Medicine* for February 1, in which the above statements appeared, was handed to your Observer by the only woman on the MEDICAL ANNALS editorial staff. She was in high glee because the editor of *PM*, taking note of the increasing number of women medical students and the prejudice which is said to still exist, had vigorously taken up the cudgel editorially for the women medics. At the bottom of the editorial she had written the word "Amen!"

Here are the comments which evoke such hearty approbation:

> "Every day women demonstrate that they can do many things as well as men and in some endeavors are far superior to the male. And yet a great number of of people, women among them, will still not admit that the female of our species is capable of anything other than bringing up the baby and doing the housework. Sure, sure, they do these things capably, thank the Lord, and man can hope fervently that the day will never come when woman will cast aside her efficiency in this department. Nevertheless, whether we men like the idea or not, the time is fast disappearing when man is the lord of his universe. Women doctors, women lawyers, even women mechanics are competing with us in our own domain and on our own terms and the day is approaching when we can no longer win over them by an appeal to prejudice. Most men like to be known as 'good sports.' Let's face the reality that we are up against stern, though beautiful and charming, competition and say with a smile, if we can, 'Let the best man (or woman) win.' "

There is no wish on your Observer's part to take issue with the views here expressed, although honesty compels him to say he cannot go the whole way with his editorial colleague. There are certain fields in which men will always dominate, and perhaps medicine is one of them. This is not to say that there are not, and will not continue to be, great opportunities for women in the healing profession, for it is your Observer's belief that only a beginning has been made. There can be no doubt that greater numbers of women will reach eminence in the medical field.

Washington has an unusually large number of capable women physicians. One certainly cannot say that opportunities do not exist for them in the Nation's Capital. In fact, all of those with whom your Observer is acquainted are more than holding their own in competition with their male colleagues. That their services are in very great demand is shown, for example, by the inquiries received at the MEDICAL BUREAU. Certainly the situation as it exists in Washington demonstrates that women in medicine need no longer feel that they are not competing on equal terms.

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Pursuit of Health Overdone

Apparently there was much sensible discussion at a recent meeting of the Health Education Conference in New York. Speakers warned their listeners against cults, fads, and phobias. Potshots were taken at people who, in pursuit of health, force themselves to exercise and take drugs on the slightest provocation. Pictured, too, was the "athlete" boastful of his physical prowess, but who has "a hidden terror over the least deviation from the normal."

Editorializing on the views expressed at the Conference, *The Washington Star* for January 26, 1947, says:

> "For those of us who dislike exercise and who feel sometimes that we should give more thought to that occasional pain in the elbow, these are encouraging things to hear. Certainly, it is good to be told, as the conference was told by one outstanding doctor, that the pursuit of health can be greatly overdone. As this man sees it, anybody can have a 'genuinely glum time of it' trying to abide by all the rules of physical fitness; meanwhile, though, the skeptic, the careless fellow who scoffs at parallel bars and dumbbells, has fun and probably 'lives 101 years, burying many health educators.' In other words, moderation in all things—even in keeping fit. That is to say, it is fine to feel fine, but why worry one's self sick trying to feel that way? It is refreshing to have this advice from the experts."

There are a number of physicians who would do well to take note of the views expressed at the Conference. A few patients need to be cautioned about their health, but the ever present danger is that they will become too conscious of their state of well-being. Large numbers of people, as every physician knows, are very susceptible to suggestion, particularly where cancer and heart disease are concerned. The medical profession's approach to the individual and the public should therefore be calm, forthright, and confident, always taking into account the average person's limited understanding of medical matters.

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Footnotes A few weeks ago members of the Society received a letter from President-elect Raymond T. Holden, in which he stated that he proposed to give early consideration to the appointment of committees for 1947–48. He requested that Society members indicate the committees on which they would like to serve. He promised that he would endeavor to place members where they would be of the greatest value. To date there has been a very satisfactory response, many members indicating their desire to be of all help possible to Dr. Holden when he takes over the reins of office on July 1. Some have written that they have previously been assigned to inactive committees and want a real job to do. It might be explained that few committees are consistently active. Their activity varies from year to year. However, no committee has been created for the purpose of providing appointments. It has been the policy of the Executive Board to recommend the continuance of only such committees as can justify their existence. They may be dormant in one year, only to be very busy in the succeeding year. . . . Although funds have not been authorized for the $20,000,000 hospital center, plans for its erection are going ahead. As most of our members know, three Washington hospitals are involved in this project, Emergency, Garfield, and Episcopal Eye, Ear and Throat Hospital. A special hospital committee is endeavoring to decide upon a location for the center. Fifteen to thirty acres of land will be necessary, and it must be tax-exempt because of the critical tax situation in the District of Columbia. Mr. Walter Fowler, District Budget Officer, is reported to have suggested to the committee that it go to Rock Creek Park for Federally-owned land if necessary. Chairman of the committee is Major General Philip B. Fleming, Federal Works Administrator. Members besides the General are Admiral Ross T. McIntire, former Surgeon General of the Navy; Chief Justice Bolitha J. Laws of District Court; Dr. James A. Crabtree, Acting Surgeon General, United States Public Health Service; Fred Bradley, Chairman of the Building Committee, Garfield Hospital; George A. Garrett, Chairman of the Board, Emergency Hospital; Henry T. Blair of the Episcopal Eye, Ear and Throat Hospital; Dr. Daniel Seckinger of the District Health Department; Robert M. Meehan, representing the public; Alan Johnstone, General Counsel of Federal Works Agency; and W. Meade Keller, solicitor of the Public Buildings Administration. . . . Six hundred fellowships in psychiatric sciences will be created by the National Advisory Mental Health Council if Congress votes the necessary funds. The fellowships will be given in psychiatry, clinical psychology, psychiatric nursing, and psychiatric social service. Applicants qualified for career training in these fields will be eligible. Commenting upon Federally subsidized fellowships, Dr. Edward A. Strecker of Philadelphia said that the Nation possesses less than one third of the psychiatrists required to fulfill minimal needs, and that there is also a shortage of psychologists, nurses, and social service workers. Members of the Council, aside from Dr. Strecker, are Dr. William C. Menninger of Topeka; John Romano of Rochester, N. Y.; David M. Levy of New York; George Stephenson, Medical Director of the National Committee for Mental Hygiene; and Frank T.

Tallman, Mental Health Commissioner of Ohio. . . . Governor Warren of California is again endeavoring to secure enactment of a bill providing for prepaid medical and hospital care to an estimated 5,000,000 Californians. The Governor is quoted as saying, "The purpose of this act is to provide a system of prepaid medical and hospital care through which the people of California will have economic access to medical, laboratory and hospital services, not as charity but as something that has been individually purchased by them on the insurance principle, without changing the traditional relationship between patient, doctor and hospital." Encouragement in the "development of voluntary prepaid health and hospital insurance plans," the Governor says, is one of his aims. More limited in scope than the bill which the Governor presented to the Legislature in 1945, it contemplates covering all persons within the Federal-state unemployment compensation system, and their families; all state, city, county and other political subdivision employees but not Federal workers; self employers who desire to come in and employees not under the unemployment compensation system where their employers elect to enter the state system. The program proposed by the Governor would be administered by a director and a health authority consisting of three doctors, one dentist, two employees, and two employers, and the State Director of Public Health. Opposition to this legislation is led by the California Medical Association, which believes there is no need for this program as its prepayment plan, California Medical Service, is rapidly expanding to serve greater numbers of the State's population. . . . Officers of medical societies find the indifference of many doctors in their organizations most difficult to overcome. Too many never bother to look at letters or notices sent to them. Some say frankly that they lay medical society communications to one side for perusal later, or consign them to the wastebasket. There is no solution to this problem except to endeavor to impress upon physicians that their indifference may prove embarrassing if not costly. Knowing the carelessness of many physicians in regard to their mail, it has been the practice of the Society's office to send two or even three notices of meetings where there is any question as to attendance. If a program has wide appeal, repeated mailings are, of course, not necessary. Somehow, the news usually gets about. But this does not always follow, as the Editor of the *Bulletin of the Jackson County Medical Society* (Kansas City, Missouri) pointed out recently. Many members still come up with this old one—"I didn't know a thing about it." Your Observer recalls instances where physicians have called the Society's office wanting to attend dinners that were held a week before, or coming to the Society's building for a meeting held two or three days before. There is much less of this sort of thing than there used to be in the District. In fact, there is evidence that more of our members are reading their Society communications and the other material sent them. Perhaps they have learned that there is much to be gained by doing so and much to be lost by being indifferent.

T. W.

MEETINGS

Wednesday, April 16

The following program will be sponsored by the *Washington Academy of Surgery*:

"Vagotomy," WALTMAN WALTERS, M.D., F.A.C.S., Professor of Surgery, Mayo Foundation

Wednesday, April 30

SYMPOSIUM ON CRANIOCEREBRAL INJURIES

The Symposium will be presented by the *Section on Neurology and Psychiatry*. The program will be as follows:

"The Differential Diagnosis and Management of Head Injuries," W. A. GUSTAFSON, M.D., Assistant Professor of Neurology and Neurological Surgery, University of Illinois

"Head Injuries in Children," VASILIOS S. LAMBROS, M.D., Children's Hospital

Discussants: OSCAR H. FULCHER, M.D., JOHN P. GALLAGHER, M.D., JAMES P. MURPHY, M.D., HUGO RIZZOLI, M.D., AND JAMES W. WATTS, M.D.

WHY NOT POINT WITH PRIDE?

C. H. Crownhart

Managing Editor, The Wisconsin Medical Journal

Editor's Note: Among state medical journals, the *Wisconsin Medical Journal* ranks with the best. No reader needs to be told that a great deal of time and effort goes into its publication. For its pages bear eloquent testimony to this fact.

As in all successful undertakings, the *Journal* has in the driver's seat an able Managing Editor, C. H. Crownhart, who is also Secretary of the State Medical Society of Wisconsin. Mr. Crownhart was a successful practicing attorney before succeeding his brother, the late J. George Crownhart. "Charlie," like George, is widely known as one of the ablest executives in the medical organization field.

The State of Wisconsin joined the Union nearly one hundred years ago. It ranks thirteenth in population, twenty-fifth in area, and yields in enthusiasm not even to Senator Claghorn in its rugged self-pride in Badger State glories.

One of those is the "Wisconsin Idea." It has best been defined, perhaps, as a realistic theory of government which understands the relative importance of "human rights" in our socio-political activities. Basically, it revolves about the belief that only through a sound social structure, educationally, morally, and economically, can there be a sound political structure.

This type of forward thinking has given Wisconsin the honor of having created many a "first" in legislation. The Workmen's Compensation Act, passed in 1911, is one of the "firsts" that people in Wisconsin like to use as an example.

Now, then, it is not surprising that this philosophy came to the fore in the field of compulsory sickness insurance. Back in 1938, at the National Health Conference, Professor E. E. Witte of Social Security Board fame, expressed the hope that Wisconsisn would create another "first" to its credit—this time in "compulsory health insurance."

Whatever may be the merit in being first in something new, there is also merit in trying to be first in something old; and the profession in Wisconsin is joined with the majority of the profession nationally in its determination that there shall be continued public health progress through voluntary means, and that there shall not be developed by the Government paternalistic activities that will result in hampering the forward movement in the health accomplishments of the people.

In taking this position, in Wisconsin as elsewhere, medicine and its organizations often find themselves bitterly assailed by those in disagreement. It matters not the source, if the criticism itself gradually becomes accepted by more and more of the people as bearing at least a modicum of truth.

Medicine cannot simply ignore it. Nor has it. But perhaps it should be a bit more active in fighting it.

It's time, it would seem, to "point with pride"—not to the health accomplishments of our people compared with those of other lands, for it is of little comfort to some, who may think themselves hungry, that others are hungrier.

Nor does it seem entirely pertinent, at least as a single argument, to emphasize the relatively low cost of total expenditures in the field of health care compared to total expenditures in luxury living. The "rugged" individual of this country is not as interested in what group statistics may be as in what *his* particular statistics are.

Certainly organized medicine must continue not only to seek improvement in existing programs that are conceded as governmental responsibilities, but to seek better housing, better clothing, adequate food and better education. These and many another constitute telling arguments, and important ones.

But there is another that must be made. And the time has come to make it—make it stick, make its truth self-evident, and its logic crystal-clear in simplicity.

The professional organizations ot medicine are nothing more and nothing less than the physicians of the country. They possess no characteristics as a group that they do not possess as individuals. Medicine has accomplished strength through voluntary organizations with common objectives, the caring for the sick and the distressed, and the alleviation of suffering and pain.

Medicine, as has been aptly observed, is the only group that works for the destruction of that which causes it to exist.

Medical men deal with the individual, not with a commodity. And in dealing with the individual, they deal with human life itself.

The sick place confidence in their physician in the most fundamental of all human emotions, self-preservation.

The trust exhibited there must go not only to the physician's judgment in method of treatment, but to the manner under which the method itself may be prescribed.

The physician in every waking hour thinks in terms of preventive medicine as well as curative medicine.

Panaceas of paternalistic programs cannot substitute for basic health education.

The American Medical Association, the Medical Society of the District of Columbia, the state and county medical societies express the considered and studied judgment of the overwhelming majority of the patients' doctors—to the citizen, *his* own doctor.

PROPOSED UNIFORM STATE BARBITURATE ACT

AN ACT TO REGULATE THE HANDLING, SALE AND DISTRIBUTION OF BARBITURATES

Finding and Declaration of Policy and Purpose

The Congress of the United States hereby finds that it is essential to the public health and safety to regulate and control the handling, sale, and distribution of barbiturates in the District of Columbia as defined in this Act.

It is therefore hereby declared to be the policy and intent of the Congress and the purpose of this Act to regulate and control such handling, sale, and distribution, and, in particular, but without limitation of such purpose, to ensure that the public shall receive the therapeutic benefits of barbiturates under medical supervision to the full extent required to assure safety and efficacy in their use; to complement and supplement the laws and regulations of the Congress of the United States and the appropriate agencies of the Federal Government affecting such handling, sale, and distribution; to prevent such handling, sale, or distribution for harmful or illegitimate purposes; and to place upon manufacturers, wholesalers, licensed compounders of prescriptions, and persons prescribing such drugs, a basic responsibility for preventing the improper distribution of such drugs to the extent that such drugs are produced, handled, sold, or prescribed by them.

Be it enacted by the Congress of the United States.

Definitions

Sec. 1. For the purpose of this Act—

(a) The term "Barbiturate" means the salts and derivatives of barbituric acid, also known as malonyl urea, having hypnotic or somnifacient action, and compounds, preparations and mixtures thereof.

(b) The term "delivery" means sale, dispensing, giving away, or supplying in any other manner.

(c) The term "patient" means, as the case may be, (1) the individual for whom a barbiturate is prescribed or to whom a barbiturate is administered, or (2) the owner or the agent of the owner of the animal for which a barbiturate is prescribed or to which a barbiturate is administered.

(d) The term "person" includes individual, corporation, partnership, and association.

(e) The term "practitioner" means a person licensed by law to prescribe and administer barbiturates.

(f) The term "pharmacist" means a person duly registered with the State Board of Pharmacy as a compounder, dispenser, and supplier of drugs upon prescription.

(g) The term "prescription" means an order, by a practitioner to a pharmacist for a barbiturate for a prticular patient, whch specifies the date of its issue, the name and address of such practitioner, the name and address of the patient (and, if such barbiturate is prescribed for an animal, the species of such animal), the name and quantity of the barbiturate prescribed, the directions for use of such drug, and the signature of such practitioner.

(h) The term "manufacturer" means persons other than pharmacists who manufacture barbiturates, and includes persons who prepare such drugs in dosage forms by mixing, compounding, encapsulating, entableting, or other process.

(i) The term "wholesaler" means persons engaged in the business of distributing barbiturates to persons included in any of the classes named in subdivisions (1) to (6) inclusive of Section 4.

(j) The term "warehouseman" means persons who store barbiturates for others and who have no control over the disposition of such barbiturates except for the purpose of such storage.

PROHIBITED ACTS

Sec. 2. The following acts, the failure to act as hereinafter set forth, and the causing of any such act or failure are hereby declared unlawful except as provided in Sections 3 and 4:

(a) The delivery of any barbiturate unless—

(1) Such barbiturate is delivered by a pharmacist, upon an original prescription, and there is affixed to the immediate container in which such drug is delivered a label bearing (A) the name and address of the owner of the establishment from which such drug was delivered; (B) the date on which the prescription for such drug was filled; (C) the number of such prescription as filed in the prescription files of the pharmacist who filled such prescription; (D) the name of the practitioner who prescribed such drug; (E) the name and address of the patient, and if such drug was prescribed for an animal, a statement showing the species of the animal; and (F) the directions for use of the drug as contained in the prescription; or

(2) Such barbiturate is delivered by a practitioner in the course of his practice and the immediate container in which such drug is delivered bears a label on which appear the directions for use of such drug, the name and address of such practitioner, the name and address of the patient and, if such drug is prescribed for an animal, a statement showing the species of the animal.

(b) The refilling of any prescription for a barbiturate unless and as designated on the prescription by the practitioner. In no instance will more than 3 refills be permitted. No refills may be made after the expiration of 90 days from the date originally filled. No prescription may be refilled within a period less than the number of days required to use the prescribed amount in the dosage prescribed.

(c) The delivery of a barbiturate upon prescription unless the pharmacist who filled such prescription files and retains it as required by paragraph (c) of Section 5.

(d) The possession of a barbiturate by any person, unless such person obtained such drug on the prescription of a practitioner or in accordance with Section 2 (a) 2.

(e) The refusal to make available and to accord full opportunity to check any record or file, as required by Section 6.

(f) The failure to keep records as required by paragraph (a) or (b) of Section 5.

(g) The using of any person to his own advantage, or revealing, other than to an officer or employee of ______ or to a court when relevant in a judicial proceeding under this Act, any information required under the authority of Section 6, concerning any method or process which as a trade secret is entitled to protection.

EXEMPTIONS

Sec. 3. Nothing in this Act shall apply to a compound, mixture, or preparation containing salts or derivatives of barbituric acid which is sold in good faith for the purpose for which it is intended and not for the purpose of evading the provisions of this act if—

(a) Such compound, mixture, or preparation contains a sufficient quantity of another drug or drugs, in addition to such salts or derivatives, to cause it to produce an action other than its hypnotic or somnifacient action; or

(b) Such compound, mixture, or preparation is intended for use as a spray or gargle or for external application and contains, in addition to such salts or derivatives, some other drug or drugs rendering it unfit for internal administration.

Sec. 4. The provisions of paragraphs (a) and (e) of Section 2 shall not be applicable (a) to the delivery of barbiturates to persons included in any of the classes hereinafter named, or to the agents or employees of such persons, for use in the usual course of their business or practice or in the performance of their official duties, as the case may be; or (b) to the possession of barbiturates by such persons or their agents or employees for such use:

(1) Pharmacists

(2) Practitioners

(3) Persons who procure barbiturates (A) for disposition by or under the supervision of pharmacists or practitioners employed by them, or (B) for the purpose of lawful research, teaching, or testing, and not for resale.

(4) Hospitals and other institutions which procure barbiturates for lawful administration by practitioners.
(5) Officials and designated employees of the District of Columbia.
(6) Manufacturers and wholesalers.
(7) Carriers and warehousemen.

RECORDS

Sec. 5. (a) Persons (other than carriers) to whom the provisions of Section 4 are applicable shall (1) make a complete record of all stocks of barbiturates on hand on the effective date of this Act and retain such record for not less than two calendar years immediately following such date, and (2) retain each commercial or other record relating to barbiturates maintained by them in the usual course of their business or occupation, for not less than two calendar years immediately following the date of such record.

(b) Pharmacists shall, in addition to complying with the provisions of subsection (a), retain each prescription for a barbiturate received by them, for not less than two calendar years immediately following the date of the filling or the date of the last refilling of such prescription, whichever is the later date.

Sec. 6. Persons required to keep files or records relating to barbiturates by Section 5 shall, upon the written request of an officer or employee duly designated by the ____________, (1) make such files or records available to such officer or employee, at all reasonable hours, for inspection and copying, and (2) accord to such officer or employee full opportunity to check the correctness of such files or records, including opportunity to make inventory of all stocks of barbiturates on hand; and it shall be unlawful for any such person to fail to make such files or records available or to accord such opportunity to check their correctness.

REGULATIONS

Sec. 7. The ____________ is hereby authorized to promulgate necessary regulations for the administration and enforcement of this Act.

PENALTIES

Sec. 8. Any person who violates any of the provisions of Section 2 of this Act shall upon conviction thereof, be subject to imprisonment for not more than one year, or a fine of not more than five hundred dollars, or both such imprisonment and fine; but if the violation is committed after a conviction of such person under this Act has become final, such person shall be subject to imprisonment for not more than two years or a fine of not more than one thousand dollars, or both such imprisonment and fine.

SEPARABILITY CLAUSE

Sec. 9. If any provision of this Act is declared unconstitutional or the applicability thereof to any person or circumstances is held invalid, the constitutionality of the remainder of the Act and the applicability thereof to other persons and circumstances shall not be affected thereby.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, February 24, 1947, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

Robert A. Cohen, 3806 Livingston Street, N.W.
Agnes Conrad, 5100 Jamestown Road
Ambrose H. Cook, 2922 Tennyson St., Chevy Chase, D. C.
Edward Harvey Cushing, Verterans Administration.
Joseph M. Daly, 8300 16th Street, Silver Spring, Md.
Howard A. Donald, 3130 Wisconsin Avenue, N. W.
Jerome D. Frank, 2651 Connecticut Avenue, N. W.
Joseph M. Friedman, 1730 Eye Street, N. W.
George D. Gartland, 926 Pennsylvania Avenue, S. E.
Thorval L. Hickman, 1843 Burke Street, S. E.
Herbert E. Martyn, Jr., 1332 Massachusetts Avenue, N. W.
John A. Mitchell, 1417 Park Road, N. W.
Lawrence A. Pyle, Jr., 1625 Massachusetts Avenue, N. W.
Leonard B. Rose, 3806 Davis Place, N. W.
Frederick H. Scharles, 2633 16th Street, N. W.

Associate Members

Samuel Allen, 18 Fawcett Street, Kensington, Md.
Bruce T. Benjamin, 4710 Glenbrook Parkway, Bethesda, Md.
Anna Catharine G. Knop, 1801 K Street, N. W.
Lee Bruner Snow, 914 Sligo Avenue, Silver Spring, Md.
Rowland F. Wilkinson, 4404 Queensbury Rd., Riverdale, Md.

The following applicants for membership will be voted on at the meeting of the Executive Board, April 28, 1947:

For Active Membership

Alfred B. Brotman, George Washington University—1943
John Paul Carter, George Washington University—1945
Alger Burr Doland, George Washington University—1945
Richard Gitter, University of Vienna—1927
Roy Hertz, University of Wisconsin—1939
Mason Morris, Jr., Georgetown University—1939
Joseph Rose, Howard University—1932
George Nathaniel Schiff, Northwestern University—1925
Charles W. Thompson, George Washington University—1941

(*Continued on page 171*)

Washington Physicians of Yesterday

CHARLES WILLIAMSON RICHARDSON, M.D., Sc.D.

Dr. Charles Williamson Richardson was born August 22, 1861, in Washington, D. C. He studied medicine in the medical departments of the Columbian (later George Washington) University and the University of Pennsylvania, and received the degree of M.D. from both of them in 1884. He then pursued further study in Europe, after which he lived the remainder of his life in Washington, where he attained the highest professional and civic eminence. His special field of practice was otolaryngology, in which he was one of the pioneers and leaders and attained a national and international reputation. He was a member and president of the various national organizations devoted to his specialty; and he was professor of the subject in the George Washington Medical School from 1891 to 1924. George Washington University and the University of Pennsylvania both granted him the honorary degree of Doctor of Science; and he was a Fellow of the Royal College of Medicine in England.

Upon the organization of the Medical Reserve Corps of the United States Army in 1908, Dr. Richardson was included in the first contingent who were commissioned in its ranks, in which he attained the grade of Colonel. During

(*Continued on page 171*)

THE WASHINGTON INSTITUTE OF MENTAL HYGIENE: ITS ORIGIN AND FUNCTION

Sidney Berman, M.D.

Director, Washington Institute of Mental Hygiene

Historical Development

The Washington Institute of Mental Hygiene, a community psychiatric clinic for children and adults, was the creation of socially-minded physicians and citizens of Washington in an endeavor to meet the mental hygiene needs of the city. How well they planned for these community needs is shown by the fact that the Institute has become a permanent structure in the National Capital area. In 1928 certain members of the medical profession, foremost of whom were Dr. William Alanson White, of St. Elizabeths Hospital, and Dr. Loren B. T. Johnson, and other interested individuals, established the Life Adjustment Center in which psychiatrists, internists, psychiatric social workers, clergymen, and others rendered professional services to those who desired help in solving their personal problems. Within a short time it was recognized that most of the problems were psychiatric in nature, as the result of which the Center became a psychiatric clinic, primarily on a volunteer basis.

Two years later (1930), a Child Guidance Clinic was established after consultation with the National Committee for Mental Hygiene and the Washington Community Chest. Once more the members of the staff of St. Elizabeths Hospital and other interested citizens supported the development of this Clinic.

By 1932 there was an amalgamation of both clinics into the Washington Institute of Mental Hygiene, financed by the Community Chest. In 1936 the Institute was established in its present home, the Berliner House, 1464 Columbia Road, N.W. This building perpetuates the name of a great scientist and humanitarian, Emile Berliner, who with such men as Dr. George Martin Kober contributed much to the establishment of the present health regulations of the District of Columbia and to preventive medicine in general. The growth of the Institute has been rapid, so that at this time it is the largest clinic for children and adults in Washington. During the early years much of the work was directed toward diagnostic and consultation services. For the past several years emphasis has been placed on treatment, with an increasing amount of time devoted to the emotional problems of each patient.

Personnel of the Institute

The present professional staff of the Institute is made up of a full-time director-psychiatrist, an additional full-time psychiatrist, 5 part-time psychiatrists in the Night Clinic, 2 clinical psychologists, and 5 psychiatric social workers. Representing the medical profession on the Board of Managers are Dr. Winfred Overholser, President of the Board, Dr. Dexter M. Bullard, Dr. Andrew Browne Evans, Dr. J. K. Fuller and Dr. Frieda Fromm-Reichmann. Other members of the Board of Managers consist of persons who realize the importance of the Institute in the community and who are willing to lend their support to furthering the aims of the Institute.

All members of the professional staff have had extensive experience in their specific specialties, as well as in allied psychological fields. Each function of the Clinic is under direct medical supervision. In the Adult Clinic patients are treated almost exclusively by a psychiatrist. In the Children's Clinic there is a pooling of the resources of the psychiatrist, clinical psychologist, and psychiatric social worker in the understanding of the causative factors and in the treatment of child-parent emotional problems. All patients' problems are evaluated by the Director before the patient is accepted for treatment, and once the patient is accepted, there is psychiatric supervision by the physician during the entire course of treatment.

How the Institute Functions

The purpose of the Institute is three-fold: first, to establish a center for the study, examination and treatment of patients who have mental maladjustments which may be subject to psychiatric treatment; second, to present an educational program of lecture courses, conferences and staff meetings for workers in allied social agencies, coöperating with and supplementing the work of the Institute; and lastly, to sponsor a general mental hygiene educational program for the public. The following remarks are confined to that area of Clinic functions devoted to the treatment of patients.

The Source of Referral. Many patients are referred by psychiatrists, pediatricians, hospitals, and by general practitioners, internists and allergists. The majority of patients, however, are self-referrals, having heard about the Institute from others who have been benefited, or having recognized the importance of psychiatric treatment for their specific emotional difficulties. Many patients are also referred by social agencies, schools, and Government agencies. Any patient unable to obtain private psychiatric treatment, and capable of using psychotherapy in the Clinic, is accepted.

Problems Referred. Among adults, psychosomatic complaints, anxiety, disturbed family and social relationships, phobias, depression and work maladjustments are the most common complaints. With children, physical symptoms without organic basis, mannerisms, tics, enuresis, fears, difficulties in school or with members of the family, and social rebellion are most often noted.

Procedure. Each adult patient, or, in the Children's Clinic, each parent, is seen by appointment at the initial intake study to evaluate the problem and to determine if the Clinic or other community resources are indicated. If accepted, the function of the Clinic is clarified and a fee is set in keeping with the financial status of the family. There are definite therapeutic advantages to this. However, no patient is refused treatment because of financial reasons, and no patient in the Adult Clinic is accepted if he is able to afford private psychiatric care. In the Children's Clinic, since psychiatric facilities for treatment are deplorably limited in Washington, cases will be accepted in order of application regardless of income, providing private facilities have been exhausted by those who are able to obtain such services. Fees obtained amount to 15 per cent of the total cost of operation of the Clinic and are submitted entirely to the Community Chest, which establishes the annual operating budget of the Clinic.

In the initial study there is ruled out any disturbance in the physical functioning of the patient. Treatment is based on knowledge of the genetics of human behavior, and the application of therapeutic measures useful in effecting a desirable change. On an average patients are treated once a week. For those adults unable to attend the Clinic during the day, a Night Clinic is held each Wednesday evening.

During the past year, the Institute treated approximately 700 patients in both Clinics. However, there is an ever-increasing demand on the part of the community for more and more services, which we find hard to meet within our available means. It is estimated that approximately 900 potential patients cannot be accepted for treatment each year because of the overload. However, all patients referred to the Institute are seen at least in consultation, and no one is turned away. This demand for psychiatric service is a reflection on the lack of sufficient facilities in Washington to meet community needs, as was pointedly set forth in the Metropolitan Health Survey. Although the Washington Institute of Mental Hygiene feels the pressure exerted on the staff because of very serious limitations, the quality of psychiatric service rendered the community has been of unusually high calibre. One of the prerequisites for the successful operation of such a community clinic is a close liaison between the Institute and the medical profession.

CORRESPONDENCE

WASHINGTON, D. C., January 10, 1947

MR. THEODORE WIPRUD
1718 M STREET N.W.
WASHINGTON, D. C.

DEAR MR. WIPRUD:

For some time I have had it in mind to write you concerning a problem we have regarding the issuance of prescriptions for sedatives to alcoholics by physicians who do not know the individual patient.

The situation we face was exemplified the other day by a woman who was brought in from one of the downtown department stores late in the afternoon. She had been drinking and was in a weak and dazed condition. In searching her purse and pockets our matron found three bottles of capsules containing nembutal, barbital and similar sedatives secured on prescriptions from three different physicians within three days time. She had also received and had filled prescriptions from two of the physicians for paraldehyde most of which she had taken at the time of arrest.

The prescriptions for the sedatives were for two dozen capsules each. None of the doctors when contacted had known the patient as a regular patient nor had they known that she was going to other doctors at the same time. She told them she was "jittery" and they gave her something to quiet her down. As a result of her condition at the time she was picked up this patient had to be taken to Gallinger where she remained under treatment from December 20, 1946 through December 30, 1946. As we have quite a number of these persons it adds materially to the public expense.

I am wondering if it would be possible for your association to give some thought to this situation and try to work out with the physicians who are members of the association some plan whereby this type of difficulty could be prevented? Whatever can be done will not only be appreciated by us but will be of considerable benefit I feel certain both to the patients and to the community which bears the expense of their care.

Sincerely,
RHODA J. MILLIKEN
Director, Woman's Bureau,
Metropolitan Police Department

By direction: Major and Superintendent

WASHINGTON, D. C., February 13, 1947

THE READER'S DIGEST ASSOCIATION, INC.
353 FOURTH AVENUE
NEW YORK 10, NEW YORK

DEAR SIRS:

I read the article, "Chiropractic Presents Its Case," in the February issue of your valuable journal. It was not much of a case, and I would not comment concerning it if it were not for the fact that newspapers lately have been carrying paid ads urging people to read it.

It seemed to me to consist mostly of quotations from writings and speeches of Doctors of Medicine which were lifted bodily out of texts to bolster up Chiropractic's case. By the same process you can prove that the Bible condones suicide. One quotation might be, "Judas went out and hanged himself." This can be followed by another quotation elsewhere in the text, "Go, thou, and do likewise."

The article suggests that Chiropractic is being persecuted by the Doctors of Medicine. I do not believe that this is true. Doctors of Medicine do not have any quarrel with any form of treatment if the practitioner can demonstrate sufficient knowledge, skill, and experience to understand the disease that he is attempting to treat. He must be able to differentiate between diseased conditions. When he has obtained sufficient education, the Doctors of Medicine will treat him as an equal and include him in their medical societies. Witness the case of Homeopathy. Homeopathy was not recognized by the Doctors fifty years ago. Today Homeopaths are members of the American Medical Association, and they enjoy all the privileges of Doctors of Medicine. No distinction is made between them and other Doctors.

Most people who seek medical advice do so for the comfort they obtain when the doctor says their trouble is not serious or for the purpose of obtaining relief from annoying symptoms. Most people would eventually recover their health if they did not consult any doctor. Therefore, most people who patronize any of the cults would recover anyhow—sometimes in spite of the treatment they receive. The other patients, however, need the best advice obtainable in order to prolong their lives. Doctors of Medicine have these people in mind when they criticize the uneducated and unprepared practitioner of any cult. Appendicitis, peptic ulcer, diphtheria, osteomyelitis, anemias, early cancer, organic heart disease, and early tuberculosis are some of the diseases which require accurate diagnosis and prompt treatment. Valuable time is lost by these patients if they do not receive proper medical advice.

Mr. Weiant answers the charge that Chiropractors are ignorant and untrained and are products of diploma mills by stating that in 1939, the Chiropractic profession set up a code of standards for approved schools of Chiropractic. He states that in January, 1947, eight years later, five schools have been approved. I do not know how many schools of Chiropractic are in existence, nor how many teach by mail, but five schools must be a small percentage.

Since February, 1929, the authorities of the District of Columbia have required that applicants for licenses to practice the healing art pass an examination in the basic subjects. After the applicant has answered the questions on basic subjects he is then examined on subjects included in the courses he has taken in Chiropractic, Osteopathy, Neuropathy, and so forth. The Health Officer advised me recently that no Chiropractor and no Naturopath has been admitted to practice by examination in Washington since that time. This, I think, describes the case of Chiropractic.

This letter contains my own personal observations and is not official in any respect.

Very truly yours,
JAMES A. GANNON, M.D., F.A.C.S.
Member, Board of Education, Washington, D.C.; Member, Radio Education Committee, The Medical Society of the District of Columbia.

News and Personals

The Chairman of the **Committee on National Emergency Service of the American Medical Association** urges every physician who received the "Questionnaire on Medical Care of Civilians during World War II" to respond promptly. It is preferable that the physician sign his name, but if anyone wishes to remain anonymous, he may do so.

On the basis of answers to these questionnaires it is hoped that facts may be determined as to how the civilian population was served in World War II. The questionnaires also provide an opportunity for those who were responsible for civilian care in those years to indicate what changes should be made in the mobilization of medical service in future emergencies.

The Committee received excellent coöperation from the 50,616 former medical officers who were mailed questionnaires last December on their experiences in military service. The facts obtained from them will be used as a basis for recommendations to be made by the Committee in June to the House of Delegates.

With the coöperation of the 5,000 physicians who are now receiving questionnaires on their civilian experience, the Committee will be able to complete the total study of how the medical profession can best serve our population, civilian and military, in the event of a future national emergency. The 5,000 questionnaires sent out represent a very small percentage of the total number of physicians who remained in civilian practice.

Members of the Society should not delay in making hotel reservations for the **Centennial Convention of the AMA** in Atlantic City, June 9–13. The official blanks for hotel accommodations were printed in the AMA Journal, October 12 and 19 issues. Dr. Robert A. Bradley is Chairman of the Subcommittee on Hotels. He may be addressed at 16 Central Pier, Atlantic City, N. J.

CALENDAR OF MEETINGS

February 1	Executive Board of Woman's Auxiliary
February 3	Obstetrical Board Subcommittee on Program, Annual Scientific Assembly Washington Ophthalmological Society
February 6	Section on Neurology and Psychiatry
February 7	Committee on Radio Education
February 8	Washington-Baltimore Psychoanalytic Society
February 11	Graduate Nurses' Association
February 12	Scientific Meeting of Society Woman's Auxiliary
February 17	Section on Pathology and Laboratory Medicine
February 18	Board of Censors
February 19	Subcommittee on Program, A.S.A.
February 20	Department Medical Advisers of The American Legion
February 21	Department Medical Advisers of The American Legion
February 22	Department Medical Advisers of The American Legion
February 24	Executive Board Subcommittee on Finance, A.S.A.
February 25	Association of Undergraduate Practical Nurses of D. C.
February 26	Scientific Meeting of Society
February 28	Graduate Nurses' Association

The Annual Meeting of the Mid-Atlantic Section of the American Urological Association will be held in Washington, March 20–22, with headquarters at the Statler Hotel. The principal speakers will be Dr. Charles McMartin, Omaha, Nebraska, President of the Association; Dr. E. Granville Crabtree, Boston, President-elect; Dr. R. M. LeComte, Washington, President of the Mid-Atlantic Section of the Association.

Dr. Louis A. M. Krause, Associate Professor of Medicine, University of Maryland, addressing members of the Medical Society of the District of Columbia, January 29.—*Photos by Dr. Leslie H. French*

The Regional Meeting of the American College of Physicians for Maryland and the District of Columbia will convene in Baltimore, April 5, at the University of Maryland School of Medicine and Johns Hopkins Hospital. Luncheon will be served at the Welsh Memorial Library.

The Silver Spring Academy of Medicine will hold its next meeting on April 7. Dr. Charles F. Geschickter, consulting pathologist in the U. S. Navy, will speak on "Lesions of the Breast." His paper will be discussed by Dr. Oscar B. Hunter.

The Eleventh Annual Postgraduate Institute of the Philadelphia County Medical Society will be held on the Roof Garden of the Bellevue-Stratford Hotel in Philadelphia, April 15–18, 1947. The theme of the meeting will be "Symposia on Medical Progress."

Among the subjects to be covered are thyroid problems, diabetes, vitamins and hormones, intestinal disorders, kidney pathology, peripheral vascular diseases, antibiotics, hypertension, diseases of the lung, neuropsychiatry, stomach and duodenum, allergy, skin disorders, and otolaryngological diseases. There will also be two evening meetings at the Society's building on the subjects of childhood and infancy disorders, and obstetrical and gynecological problems.

The registration fee for the entire course is $5.00 for non-members of the Society. Out-of-town physicians planning to attend the meeting are urged to make their hotel reservations immediately.

For further information write to Dr. Gilson Colby Engel, Director, 301 South 21st Street, Philadelphia 3, Pa.

The Maryland-District of Columbia Chapter of the American College of Chest Physicians will meet at the Belvedere Hotel, Baltimore, April 21, preceding the semi-annual meeting of the Medical and Chirurgical Faculty of the State of Maryland. The following program has been scheduled:

"Sarcoidosis," Sol Katz, M.D., Instructor of Clinical Medicine, Georgetown University School of Medicine

"Congenital Atresia of the Esophagus," Cameron Haight, M.D., Assistant Professor of Surgery, University of Michigan School of Medicine

"The Surgical Treatment of Pulmonic Stenosis," Alfred Blalock, M.D., Professor of Surgery, Johns Hopkins University School of Medicine

"Chemotherapy of Tuberculosis," John A. Kolmer, M.D., Professor of Medicine, Temple University School of Medicine

"Correlation of Various Branches of Medicine and Surgery as Related to Diseases of the Chest," J. Winthrop Peabody, M.D., Professor of Diseases of the Respiratory System, Georgetown University School of Medicine.

The Third Annual Convention of the American Society for the Study of Sterility will be held at the Hotel Strand, Atlantic City, New Jersey, on June 7 and 8, 1947, preceding the AMA Convention. Additional information may be secured by writing to the Secretary, Dr. John O. Haman, 490 Post Street, San Francisco 2, California.

The American College of Surgeons is conducting a series of 8 sectional meetings throughout the United States and Canada. A number of Washington physicians attended the meetings held March 10 and 11 at the Lord Baltimore Hotel, Baltimore. **Dr. Charles S. White** presided at the two major panel discussions on March 10.

The American College of Physicians announces that its 28th annual session will convene in Chicago, April 28–May 2, 1947. Detailed information may be secured from Mr. Edward R. Loveland, Executive Secretary of the College, 4200 Pine Street, Philadelphia 4, Pennsylvania.

Of the **postgraduate courses** which will be held during the spring months **for veteran and civilian physicians** the following may be of interest to Washington physicians. These courses were not included in the listings published in the *Journal of the AMA* for December 14 and 21.

CARDIOVASCULAR DISEASE: American College of Physicians, 4200 Pine Street, Philadelphia, at Philadelphia General Hospital, Philadelphia, May 12–17; $20 to members, $40 to non-members.

ENDOSCOPY, OPHTHALMOLOGY AND OTOLARYNGOLOGY: Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va., April 7–12; registration fee not given.

GENERAL MEDICINE: New York University College of Medicine, Postgraduate Division, 477 First Avenue, New York 16, at Bellevue Hospital; 12 weeks full time, beginning April 7; $175 to veterans, $225 to non-veterans.

OTORHINOLARYNGOLOGY: Georgetown University School of Medicine, Washington, D.C., April 7.

POLIOMYELITIS: Georgia Warm Springs Foundation, Warm Springs, Ga.; 2 weeks beginning the first Monday in April; registration fee not given.

RADIOLOGY: American College of Radiology, 20 North Wacker Drive, Chicago 6, Ill., at Philadelphia, Pa., March 31–April 4; $50 registration fee.

The first national conference of **Department Medical Advisers of the American Legion** was held in the Medical Society's building, February 20, 21 and 22. Legion medical officials representing 48 states, the District of Columbia and Hawaii were in attendance. Dr. Leonard G. Rowntree, of Philadelphia, Chairman of the Legion's Medical Advisory Board, presided at the meetings.

Amont those who appeared on the program were Major General Norman T. Kirk, Surgeon General of the Army; Rear Admiral Clifford A. Swanson, Surgeon General of the Navy; Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service; Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital; Dr. George F. Lull of Chicago, Secretary of the AMA; Dr. H. D. Shapiro, Washington; and Dr. Herman Hilleboe, USPHS.

At the dinner at the Army-Navy Club, February 21, Dr. Rowntree presided. Addresses were made by Mr. Watson B. Miller, Federal Security Administrator, Dr. Paul R. Hawley, Chief Medical Director of Veterans Administration, and Brig. General Wallace H. Graham, physician to the President.

The Medical Advisory Board consists of the following members, most of them well known to Washington physicians: Dr. Rowntree, Chairman; Dr. Howard A. Rusk, Medical Editor of the New York Times; Colonel Louis H. Renfrow, of Washington; Dr. Waltman Walters, of the Mayo Clinic; Dr. C. Raymond Wells, Brooklyn, N. Y.; Dr. William D. Stroud, of Philadelphia; Dr. Overholser; Dr. Charles W. Mayo, of the Mayo Foundation; Rear Admiral W. J. C. Agnew of the Bureau of Medicine and Surgery; Dr. Esmond R. Long, of the Henry Phipps Institute; Dr. Lull; and Dr. Albert N. Baggs, Washington, Secretary of the Board. Serving as ex officio members of the Board are Mr. T. O. Kraabel, Dr. Shapiro, and Mr. Miller, all of Washington.

Dr. Daniel Sondheimer is one of the Department Medical Advisers, representing Washington, D. C.

The Bureau of Health Education of the American Medical Association is sponsoring a series of radio broadcasts over the Mutual Broadcasting System (WOL) on Monday nights at 10:30 p.m., E.S.T. The title of the series, which began February 3 and will continue for 26 weeks, is "Doctor Graham and Family."

The program deals with a typical physician in general practice in an imaginary town of about 100,000 people, set in an agricultural county. The story centers around the community life of the doctor, his wife and their three children, and the doctor's patients. There is no medical speaker. Primarily, the program will be interpretive rather than educational.

The UNRRA Health Division, the largest international health organization the world has yet known, will wind up its activities on March 31, 1947, after more than three years of work. During this time UNRRA has made available to the health departments of 13 liberated countries the advice and assistance of its international health staff, and has also given medical and sanitation services to over a million men, women and children in the camps for displaced persons in the Middle East, Germany, Austria and Italy.

Dr. Wilbur A. Sawyer, Director of UNRRA's Health Division, who was formerly Director of the International Health Division of the Rockefeller Foundation, feels that the results of UNRRA's health work have exceeded all expectations. Europe has gone through the first year and a half after the most widespread and devastating war in history with no major epidemics. For several months past the Health Division has been handing over phases of its activity to the Interim Commission of the World Health Organization.

Twenty hospitals in the District of Columbia and Bethesda, Md., appear on the **list of hospitals approved by the American College of Surgeons** as of December 31, 1946: They are: Central Dispensary and Emergency, Children's, Columbia Hospital for Women, Doctors, Eastern Dispensary and Casualty, Episcopal Eye, Ear and Throat, Freedmen's, Gallinger Municipal, Garfield Memorial, Georgetown University, George Washington University, National Homeopathic, Providence, Saint Elizabeths, Sibley Memorial, United States Naval, United States Soldiers' Home, Veterans Administration, Walter Reed and Washington Sanitarium.

Five were approved for graduate training in surgery and/or a surgical specialty: Emergency, Freedmen's, Gallinger, Georgetown and Providence.

Approved for training interns by the Council on Medical Education and Hospitals of the American Medical Association were the following: Emergency, Doctors, Freedmen's Gallinger, Garfield, Georgetown, George Washington, Providence, Saint Elizabeths, Sibley and Washington Sanitarium.

Thirteen hospitals were approved for residencies or fellowships by the Council on Medical Education and Hospitals of the AMA: those listed just above (with the exception of Washington Sanitarium) and Children's, Columbia and Episcopal.

A new Cancer Clinic for children with suspected cancer or other tumors has been opened in **Gallinger Hospital** with funds provided by the National Cancer Institute of the USPHS. The Clinic is available to pediatricians throughout the District for laboratory tests, examination and diagnosis of children with abnormal growths. It is open every Wednesday at 12:30 a.m. in the Gallinger pediatrics clinic.

Dr. Roy Hertz, endocrinologist of the National Cancer Institute, is Director of the Clinic.

At a meeting of the **Executive Board,** January 27, approval was given to the list of members, submitted by President Herbst, who will be appointed to serve as Chairmen of the various Subcommittees for the 18th ANNUAL SCIENTIFIC ASSEMBLY:

Program—Brian B. Blades
Finance—Thomas F. Keliher
Attendance—James A. Dusbabek
Public Meeting—Oscar B. Hunter, Jr.
Public Health—William J. Tobin
Social Affairs—J. Lawn Thompson, Jr.
Scientific Exhibit—J. Ross Veal
Motion Pictures—Darrell C. Crain, Jr.
Women's—H. Gladys Kain

Dr. Robert H. Groh is Chairman of the Committee on Arrangements for the ASSEMBLY, and Dr. Robert J. Coffey, Vice Chairman.

In response to a communication from the Secretary of the District Board of Commissioners, the Board voted in favor of daylight-saving time for the District of Columbia.

The Board confirmed the appointment of **Dr. Clarence K. Fraser** to serve as a member of an advisory committee to Mr. Ray L. Huff, Director of Public Welfare. This committee will deal particularly with legislation having to do with the adoption and placement of children. Other organizations asked to appoint representatives to this committee were the District Bar Association, the Medico-Chirurgical Society, Inc., the Committee on Religious Life in the Nation's Capital, and the American Association of Social Workers.

A new publication, the *American Journal of Psychotherapy*, has made its appearance in the Medical Society's offices. This journal is the official organ of the Association for the Advancement of Psychotherapy and is a successor to the *Journal of Clinical Psychopathology and Psychotherapy*. The Editor is Dr. Emil A. Gutheil, 16 West 77th Street, New York 24, N. Y. It will be published quarterly, January, April July and October.

Surgeon General of the Army Kirk announces that the Medical Department Professional Service

Schools at Walter Reed Hospital will hereafter be known as the **Army Medical Department Research and Graduate School.** The School will continue to be a part of the Army Medical Center at Walter Reed under the command of Brig. General George C. Beach, Jr.

The Washington Medical and Surgical Society held a dinner meeting and election of officers at the Hotel Statler, January 27, which was attended by 54 physicians. Dr. George H. McLain, retiring President, presided. Dr. William E. Bageant presented a paper on "The Treatment of Pulmonary Embolus by Stellate Block" and Dr. J. E. Wissler gave a case report on "Tularemia Pneumonia." The Society voted to renew its annual **Gibson Award** for the outstanding paper of the year, a practice which was discontinued during the War.

The following officers were elected for 1947:

Dr. Norman C. Shoemaker, *President;* Dr. Leo B. Gaffney, *Vice President;* Dr. Joseph F. Belair, *Secretary.*

Dr. Frank E. Gibson is permanent Treasurer of the Society.

The Section on Neurology and Psychiatry met in the Society's library, February 6. Two papers were read: "Psychotherapy for Children," Dr. Dorothy Donley-Dowd; "Subdural Haematomas in Infancy, " Dr. Vasilios S. Lambros.

On March 6 Dr. Herman Kabat, Medical Director of the Kabat-Kaiser Institute, addressed the Section on Neurology and Psychiatry on "Rehabilitation in Various Types of Paralysis."

The members of the Section on Pediatrics were guests at these meetings.

The Washington Ophthalmological Society held a special meeeting in conjunction with the tenth annual George Washington University Postgraduate Course in Ophthalmology, February 3, in the Medical Society's building. The following program was presented: "Selected Cases of Retinal Detachment," Dr. Peter C. Kronfeld of Chicago; "The Problem of Thyrotropic Exophthalmos," Dr. F. Bruce Fralick of Ann Arbor, Michigan.

The George Washington University Medical Society held its 21st annual banquet and alumni reunion at the Mayflower Hotel, February 15. Dr. J. Burton Glenn, President of the Society, presided. Following invocation by the Reverend Richard C. Law, Professor of Religion at Georgetown University, the guest speaker, The Honorable Bolitha J. Laws, Chief Justice of the District Court of the United States, addressed members of the Society and guests.

Dr. A. C. Christie was host to the **Clinico-Pathological Society** at the Army-Navy Club, February 18. Dr. Theodore J. Abernethy presented a paper on "Experimental Transmission of Minor Respiratory Illness to Human Volunteers."

Dr. Gregory Zilboorg, of New York City, addressed the **St. Elizabeths Hospital Medical Society,** January 31, in Hitchcock Hall. His subject was "Individual Psychotherapy in War and Peacetime."

At a meeting of the **Association of Undergraduate Practical Nurses,** held in the Medical Society's auditorium, January 30, discussion centered around proposed legislation which would establish training schools and licensing for District practical nurses. A bill, prepared under the joint auspices of the Association and the Graduate Nurses' Association, has been presented to Corporation Counsel Vernon West for submission to the District Commissioners and eventually to Congress.

Speakers at the meeting were Mrs. Elizabeth Earle, Vice President of the District Examining Board for Nurses; Dr. James A. Gannon, member of the District Board of Education; Miss Edith Beattie, Executive Secretary of Graduate Nurses' Association; and Miss Bernice Ritter, Director of Nursing at Gallinger Hospital.

The American Newspaper Women's Club will endow the diabetic clinic in the new **George Washington University Hospital.** At a brief ceremony at the White House, February 7, which Mrs. Truman attended, a check for $500 was presented to President Cloyd Heck Marvin, President of the University, by the Club President, Mrs. Margaret Hart Canby.

Brigadier General Malcolm C. Grow, Air Surgeon of the Army Air Forces, was awarded the John Jeffries Award for outstanding contributions to aviation medical research. The presentation was made at a meeting of the Institute of the Aeronautical Sciences, January 27.

General Grow won the award for his study of conditions affecting the efficiency of air crews at high altitudes. He developed electrically heated clothing, gloves and boots, special combat rations for use on long bombing missions, and a special armor used by airmen for protection against shrapnel.

The award was established in 1940 to honor Dr. John Jeffries, a Boston physician who accompanied the French balloonist Blanchard on the first aerial voyage across the English Channel in 1785 and made the first scientific observations from a balloon in flight.

Dr. Brian B. Blades, Professor of Surgery at George Washington University School of Medicine, recently visited Rochester, Minn., where he delivered a lecture on chronic lung diseases before the staff of the Mayo Foundation. The invitation to address the staff was extended to Dr. Blades in recognition of his outstanding work in the field of lung surgery at the George Washington University Hospital.

Dr. William P. Herbst, President of the District Social Hygiene Society, gave the principal address at the Society's annual luncheon meeting in Barker Hall of the Y.W.C.A., February 3.

Colonel J. E. Ash, Director of the Army Institute of Pathology, and **Dr. Wallace M. Yater,** Director of the Yater Clinic, held a clinico-pathological conference in Durham, N. C., February 12, during the Fourth Annual Medical and Surgical Symposium sponsored by the Watts Hospital Staff of Durham. On February 13 **Dr. Monroe J. Romansky,** Associate in Medicine, George Washington University School of Medicine, spoke on "The Current Status of Calcium Penicillin in Beeswax and Peanut Oil."

Dr. E. H. Cushing has recently been appointed to the staff of **George Washington University School of Medicine** as Assistant Clinical Professor of Medicine. He formerly held the same appointment at Western Reserve University in Cleveland.

Another staff appointment of interest to Society members is that of **Edwin D. Neff,** *Times-Herald* news reporter, who has covered medical news in Washington previous to and following his war service with the Navy. He will be a lecturer in journalism at George Washington University.

In observance of National Heart Week, **Dr. Thomas Parran,** Surgeon General of the U. S. Public Health Service, spoke from Chicago, February 10, on a nationwide broadcast over the Mutual Network.

Dr. Arthur C. Christie has been appointed a member of a Special Medical Advisory Group to the Veterans Administration. Members will act in an advisory capacity to General Omar N. Bradley, Administrator of Veterans Affairs, and Dr. Paul R. Hawley, Chief Medical Director, on over-all policies concerning medical service to veterans. Dr. Charles W. Mayo of Rochester, Minn., is Chairman of the advisory board.

Dr. John W. Cronin, an Associate member of the Medical Society, will head the Federal Employee Health Division, recently created within the Bureau of Medical Services. Dr. Cronin was formerly medical officer in charge of the USPHS Dispensary in Washington.

Captain Leslie K. MacClatchie advises the Society's Secretary that he has transferred to the Regular Navy and will head the Department of Dermatology and Syphilology at the U. S. Naval Hospital, San Diego 34, Calif. He writes, "The Navy has an ambitious program for postgraduate training in the various specialties and this is one of the hospitals selected by the Bureau for residency type training in dermatology and syphilology."

Dr. Joseph E. Brackley has been released from service and may be addressed presently at 4 Clifford Street, Ellenville, New York. Dr. Brackley served as Captain in the Army Medical Corps.

Dr. Henry C. Macatee was the guest speaker of the Washington Club, February 4. He explained why the American Medical Association was opposed to compulsory health insurance as embodied in the Wagner-Murray-Dingell bill. **Dr. Winfred Over-**

holser addressed the same group, February 11, on symptoms and treatment of mental disorders.

Dr. Hugh S. Cumming retired as Director of the Pan American Sanitary Bureau during the 12th Pan American Sanitary Conference held in Caracas, Venezuela, January 12–24, 1947. In recognition of his 26 years of active service, without remuneration, the Conference elected him Director Emeritus. Upon the date of his retirement, January 31, he was succeeded as Director by Dr. Fred L. Soper of the Rockefeller Foundation.

Dr. Monroe J. Romansky participated in a two-day symposium on antibiotics, January 31 and February 1. The conference was sponsored by the Antibiotics Study Section, one of 23 groups of special consultants organized to aid the Research Grants Division of the National Institute of Health in the promotion of medical research.

Dr. Winfred Overholser addressed the first meeting of the National Council for Youth Entertainment at St. John's Episcopal Church, February 4. The avowed purpose of the new Council is to eliminate unsuitable entertainment for children now offered through the radio, movies and books.

Dr. Dorothy Donley-Dowd, Assistant Director of the Child Center of Catholic University, addressed the Woman's Auxiliary to the Medical Society at its regular meeting, February 12.

Dr. Dowd led a discussion on the needs and problems of young people, from 12 to 15 years of age, at a meeting at St. Vincents Home and School, February 13.

Dr. William K. Billingsley has enrolled at the University of Pennsylvania Postgraduate School for a year of specialized training in gastroenterology. Dr. Billingsley served for more than two years in the Medical Corps of the United States Naval Reserve during the War.

Dr. Frieda Fromm-Reichmann, of Rockville, Md., an Associate member of the Society, addressed the Annual Clinical Assembly on Obstetrics and Gynecology in Los Angeles, February 12.

Drs. Dean M. Hayes and G. Victor Simpson are participating as speakers in the Programs of Professional Staff Proceedings at Walter Reed General Hospital.

Theodore Wiprud, Secretary of the Medical Society, will be one of the speakers at the 1947 Conference of County Medical Society Secretaries and Editors of the Medical Society of the State of Pennsylvania to be held at the Penn-Harris Hotel, in Harrisburg, March 20 and 21.

Mr. Wiprud addressed the Woman's Auxiliary to the Prince George's County Medical Society, January 28, at the home of Mrs. George J. Hageage. His talk concerned socialized medicine.

Dr. George J. Brilmyer has moved to Pittsburgh and has accepted a position in an administrative capacity at the nearby U. S. Veterans Hospital at Aspinwall, Pa.

Dr. Dexter M. Bullard spoke at a meeting of the Sherwood High School Parent-Teacher Association in Sandy Spring, Md., February 4.

Dr. Bretney Miller has been appointed medical consultant for the House of Mercy.

HENRY ROLF BROWN, M.D.
(1868–1947)

Dr. Henry Rolf Brown, an Associate member of the Medical Society of the District of Columbia, died suddenly, February 15, at Mount Alto Hospital. He had entered the hospital for treatment ten days prior to his death.

Dr. Brown was born in San Francisco, Calif., June 23, 1868. He received his A. B. degree from the University of California in 1886 and graduated in medicine from the University of the City of New York in 1889. He continued his medical education by postgraduate study in Vienna, Paris, London and Birmingham, England, before entering private practice in San Francisco.

Early in his career he was city physician with the Health Department of San Francisco; he also practiced for a time in Providence, R. I. During

World War I he served in the Army Medical Corps as a Colonel and commanded Base Hospital No. 94 in France. After the War he was appointed Adjutant General of the State of New Mexico, but resigned after one term to assist in the organization of the Veterans Bureau hospital service.

From 1922 to 1934 he was administrator of several Veterans hospitals in the field, including that at Aspinwall, near Pittsburgh, Pa., where he resided for several years. From 1934 to 1937 he was Chief of the Tuberculosis Division of Veterans Administration. In 1937 he left this post to become Medical Director of the newly formed Group Health Association in Washington, but resigned the following year.

He was a 32nd degree Mason.

Surviving are his wife, Mrs. Eula Conkling Brown; a daughter, Mrs. Allan Day of Largo, Fla.; and a sister, Mrs. Anne Lincoln of Maine. He resided at the Stoneleigh Court Apartments.

Membership

(*Continued from page 159*)

For Associate Membership

Charles Thomas Nicholson, Jr., University of Virginia	1938
Herman I. Slate, College of Medical Evangelists	1934

Recent changes in membership status:

Active to Associate

Ella M. A. Enlows
Geneva Dye Turner

Resigned
Associate

David V. McCauley
Milton I. Roemer
Harold M. Walton

Washington Physicians of Yesterday—Richardson

(*Continued from page 160*)

World War I he was the chief representative of his specialty in the army organization, and rendered highly appreciated service in that line.

He was an active participant in the proceedings of the Medical Society of the District of Columbia, of which he was President in 1904. He was especially active and efficient in the acquisition and erection of the Society's home building in 1920; he was Vice Chairman of its Building Committee, and by his personal efforts raised a fourth of the funds required for its construction. His wife, Amy Elizabeth Small, whom he married May 27, 1889, was also active in that enterprise as chairman of the women's subcommittee which rendered much aid in the furnishing and decoration of the building. In recognition of her service a memorial tablet was installed after her death, which occurred April 17, 1937, in the library of the building. Dr. Richardson was also active in the proceedings of the American Medical Association, being a Vice President in 1919 and a member of its Board of Trustees from 1920 until his death in 1929.

Dr. Richardson was a many-sided man, of broad interests. In addition to a large and laborious practice he was a hard worker and student, and contributed some 105 articles to medical literature. He was an active and devoted member of the New York Avenue Presbyterian Church of Washington. He had an attractive personality and charming manners, being noted for his "ten-thousand-dollar smile." In his boyhood days he was an enthusiastic amateur printer and journalist, and conducted a juvenile periodical. His youthful associates in this enterprise maintained an intimate friendship throughout their lives; in later years they formed a club, named "The Fossils," the presidency of which, so late as 1927, Dr. Richardson appreciated as not the least of his honors.

After his death, which occurred August 25, 1929, a notable memorial service was held in his church, at which glowing tributes to him were expressed by many eminent dignitaries.

John B. Nichols, M.D.

MEDICAL SOCIETIES WITH LIMITED MEMBERSHIP

WASHINGTON, D. C.

1946–1947

SOCIETY	PRESIDENT	SECRETARY	NO. MEETINGS PER YEAR	DATE OF MEETINGS	PLACE OF MEETINGS
Baltimore-Washington Dermatological	M. Sullivan, Baltimore	L. B. McCaleb, Washington	8	3rd Thursday	Alternating Cities
Clinico-Pathological	J. Minor	T. J. Abernethy	8	3rd Tuesday	
Georgetown Clinical	M. J. McInerney	H. H. Hussey	7	3rd Tuesday	Hotel Statler
Georgetown University Medical Alumni Club	T. F. Keliher	R. C. Rush	3	On call	
George Washington University	J. B. Glenn	O. B. Hunter	7	3rd Saturday	School of Medicine
Hippocrates-Galen	G. K. Nutting	G. T. Sharp	5	On call	
International Medical Club	G. C. Birdsall	F. A. J. Geier	4	On call	
Jacobi	B. Golden	L. Gerber	7	4th Monday	
Kober	D. S. Knowlton	J. L. Gilbert	8	3rd Monday	
Mackall	J. E. Wissler	L. B. Gaffney	8	3rd Thursday	
Medical Arts Society*					
Osler	R. M. Page	J. L. Parks	8	3rd Monday	
Pan American (D. C. Branch)	W. Overholser	F. A. Reuter	4	On call	Roger-Smith Hotel
Physician-Veterans of World War II	W. W. Sager	S. W. Hawken		On call	
Rheumatism	D. C. Crain	M. C. Cobey	3	On call	Medical Society Building
Saint Elizabeths Hospital	G. D. Weickhardt	M. Kleinerman	3	On call	St. Elizabeths Hospital
Washington Academy of Medicine	M. W. Perry	E. C. Albritton	3	On call	Roger-Smith Hotel
Washington Academy of Surgery	B. F. Dean	V. M. Hess	4	2nd Friday Oct., Nov., Dec., Apr.	Hotel Statler
Washington-Baltimore Psychoanalytic	B. Weininger	R. Buxton	8	2nd Saturday	Medical Society Building
Washington Gynecological	L. L. Cockerille	R. T. Holden	5	4th Saturday Oct., Nov., Jan., Mar., May	
Washington Heart	F. S. Horvath	B. J. Walsh		On call	Assn. Hdqrs.
Washington Medical and Surgical	N. C. Shoemaker	J. F. Belair	3	4th Monday Oct., Jan., Mar.	Hotel Statler
Washington Ophthalmological	R. W. Wilkinson	J. A. Sansoucy	4	1st Monday Nov., Jan., Mar., May	Medical Society Building
Washington Orthopedic Club	F. M. Hand	M. Mendelsohn	7	2nd Monday	Medical Society Building
Washington Society of Pathologists	K. M. Endicott	R. A. Sloan	7	1st Saturday	Army Institute of Pathology
Washington Urological	H. A. Fowler	C. E. Bagley	7	Every 6 weeks	Doctors Hospital
Women's Medical	G. G. Purse	C. L. Fusfeld	9	1st Tuesday	Doctors Hospital

* Reorganization pending.

NOTE: Most of these societies begin their regular meetings in October and continue through April or May. The Editorial Board would appreciate information regarding any additional medical societies not shown on this list.

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STUDIES OF PNEUMONIAS IN CHILDHOOD*

JOSEPH ROSE, M.D.
PAUL D. DOOLAN†
SALLY MACDONALD, M.D.
Washington

In recent years relatively few purely clinical or statistical surveys of pneumonias in childhood have been published. This paper represents a statistical analysis of 1,534 cases of pneumonia in addition to observations made in reviewing the various methods of therapy employed in 150 other cases.

The cases studied in this series are with few exceptions those of primary pneumonia which occurred in Children's Hospital, Washington, D. C., and were either recognized in the course of an upper respiratory infection treated in the outpatient department or in the emergency ward during the period from January 1, 1943 to December 31, 1945. In the District of Columbia patients with the exanthematous and communicable diseases are isolated when necessary in the contagious disease building of Gallinger Municipal Hospital and therefore are not substantially implicated in this series.

Immediately upon admission, patients with an acute upper respiratory infection are carefully examined for pneumonia. The clinical diagnosis of lobar pneumonia is based on the definite physical signs of localized pulmonary consolidation, confirmed by radiographic examination, and terminally by necropsy. We use the term lobular pneumonia to mean the disseminated form of pneumonia as distinct from bronchopneumonia which refers to the secondary type of interstitial pneumonia. Scattered areas of bronchial breathing with crepitation, cough, prostration, a typical febrile course with hurried breathing even in the absence of opacities in the X-ray film were considered as evidence of a disseminated pneumonia, and the fact was kept in mind that this condition may exist without any signs of consolidation during its course. In more recent years, primary atypical pneumonia, etiology unknown, has been added to the hitherto standard classifications. This clinical syndrome of probably multiple etiologies usually has an insidious onset with fever (100–103°F.), racking cough and a distressing headache. There is usually more roentgenographic than clinical evidence of pneumonia, and the white blood cell count is low, normal or but slightly elevated.

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* From Children's Hospital, by the kind permission of Dr. Joseph S. Wall, Chairman of the Medical Staff.

† Senior Medical Student, Georgetown University School of Medicine.

Disproportionate bradycardia, cold agglutinins, elevated sedimentation rate, and failure to respond to chemotherapy further characterize the condition. The subjective complaints may appear out of proportion to the general appearance of the patient. Convalescence may be prolonged, complications are uncommon, and the mortality rate is probably less than 4 per cent.

TABLE 1

Age and Sex Incidence in 1,115 Cases of Lobular Pneumonia with Case Fatality

AGE	TOTAL		RECOVERED		DIED	
	Male	Female	Male	Female	Male	Female
0–6 months	125	102	88	65	37	37
6–12 months	132	90	126	84	6	6
12–18 months	93	60	92	58	1	2
18–24 months	60	52	59	49	1	3
2–6 years	162	137	157	135	5	2
6 years and over	53	49	52	47	1	2
Total	625	490	574	438	51	52

TABLE 2

Age and Sex Incidence in 368 Cases of Lobar Pneumonia with Case Fatality

AGE	TOTAL		RECOVERED		DIED	
	Male	Female	Male	Female	Male	Female
0–6 months	22	18	16	14	6	4
6–12 months	31	25	27	23	4	2
12–18 months	20	27	20	23	0	4
18–24 months	12	13	12	13	0	0
2–6 years	82	54	80	53	2	1
6 years and over	42	22	42	22	0	0
Total	209	159	197	148	12	11

In this study 1,115 cases were diagnosed as lobular pneumonia, 368 as lobar pneumonia, and 51 as primary atypical pneumonia. Of these patients, 551 or 35.9 per cent were under 1 year of age, 343 or 22.4 per cent were between 1 and 2 years of age, 448 or 29.2 per cent were between 2 and 6 years of age, and 192 or 12.5 per cent were 6 or more years old. These figures differ considerably from a previous survey of pneumonias at Children's Hospital made by Rose et al[1] in 1936. In that survey of 423 cases, 243 were diagnosed as lobar and 180 as lobular pneumonia. Further, 27.2 per cent were under 1 year of age; 21.9 per cent were between 1 and 2 years of age; 32.3 per cent were between 2 and 6 years of age; and 18.2 per cent were 6 or more years old.

The case fatality was highest among those patients with lobular pneumonia, 103 deaths (9.2 per cent) occurring in 1,115 cases. Among the patients with lobar pneumonia 23 deaths (6.3 per cent) occurred in 368 cases. Among the patients with primary atypical pneumonia 1 death (2 per cent) occurred in 51 cases. It is interesting to note that the case fatality in the youngest age group is greatest in all types of pneumonia, most fatalities occurring in the group under 6 months of age and frequently within 24 hours after admission to the hospital. This is probably due to the tender age and lessened resistance in the patient in whom it occurs (tables 1 and 2).

When the cases were divided into lobar, lobular, and primary atypical pneumonias and into those under 2 years of age and those over 2 years of age, it was found that 45.7 per cent of the lobar pneumonias occurred in infants under 2 years of age with a case fatality of 11.9 per cent, and that 64.0 per cent of the lobular pneumonias with a case fatality of 13.0 per cent occurred in the same age group. Of the primary atypical pneumonias 23.5 per cent were under 2 years of age with the single fatality occurring in a child 4 months of age. Of the lobar pneumonias 54.3 per cent occurred after 2 years of age as compared with 36.0 per cent of the lobular and 76.5 per cent of the primary atypical types. The case fatality in this age group was 1.5 per cent for lobar, 2.5 per cent for lobular, and none for atypical. It will be noted that in young infants the fatality rates for lobar and lobular pneumonias show very little difference.

Most authorities state that there is a preponderance of males suffering from primary pneumonia. When the sex incidence is tabulated for the younger ages there is found to be a moderate preponderance of males in almost every age group. In our series there were 864 males affected as against 670 females. The disproportion in adult life may be explained as a result of differences in exposure and occupation, but in infancy and childhood no reasonable explanation is available.

The commonest complications encountered in this study in their order of frequency were: otitis media. diarrhea, pertussis, measles, atelectasis, pleurisy, meningitis and meningism, congenital heart disease, and anemia.

The following portion of this paper deals with observations made in reviewing the various methods of therapy employed in 150 other cases. This group includes patients from 7 days to 10 years of age. They have been selected as follows: 50 cases maintained by supportive measure, 50 cases treated with sulfonamides, and 50 cases in which penicillin therapy was employed.

Symptomatic and supportive management was important in the entire group of cases and consisted of rest, maintenance of fluid balance, diet as indicated, adjustment of elimination, and control of hyperpyrexia by means of aspirin and sponge baths. Expectorants and nose drops were used for comfort and control of secretions. Sedation with phenobarbital was the common method of controlling central nervous system irritation. Codeine was employed effectively for control of pleural pain. Oxygen administration was extremely valuable in most cases, but an occasional case with dry râles and non-productive cough showed better response to steam inhalation. Prostigmine 1:4000 was employed to aid in combating meteorism. Stimulants including caffeine sodium benzoate, coramine, and adrenalin were resorted to as terminal measures. Adrenalin was also of value in cases with an asthmatic factor. The favorite counterirritant, the mustard plaster and the popular half dram of whiskey with soda, seems to have gone out of style when chemotherapy stepped in.

In this group the average time required for the temperature to return to normal was 8 days and the average hospital stay was 18.5 days. In the 1936 study the primary complication was found to be empyema which occurred in 20.4 per cent of the cases studied, and in this comparatively small group maintained by supportive therapy it was found to be correspondingly high, occurring in approximately 10 per cent of the 50 cases. The mortality rate in the 1936 study was 22 per cent and in this group 14 per cent.

Sulfone therapy in the group managed with sulfonamides consisted of 18 cases treated with sulfathiazole and 32 cases treated with sulfadiazine. No significant differences between these drugs were noted in toxicity or response to therapy. The average dose of sulfone administration was 1.6 grains per pound of body weight per day; the average number of days of drug administration was 5.6 days; therefore, the average total dosage was 9 grains or 0.6 Gm. per pound of body weight. The average drug level obtained was 7 mg. per 100 c.c. of blood. The temperature became normal in an average of 67 hours. Only 39 per cent of the cases in this series attained apyrexia in 40 hours or less. The average hospital stay was 9 days.

In the penicillin group, the drug was administered by the intramuscular route in all but 5 cases, 2 of which received the drug orally, while 3 received it orally and intramuscularly combined. The average number of units of penicillin administered per patient was 972,000 units. The usual dosage schedule was 20,000 units every 3 hours, but a larger initial dose, when used, appeared to produce a more rapid defervescence. The average time for the temperature to return to normal was 79 hours, and the average hospital stay was 10 days.

McLendon, Ross and Burke[2] reported 2 cases of pneumonia which have been included in this series and were treated with 100,000 units of oral penicillin every 3 hours with totals of 1,000,000 and 800,000 units respectively. In these cases the temperature dropped to normal in 12 hours.

(*Continued on page 229*)

OBLIGATION OF THE PHYSICIAN TO PSYCHIATRY*

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The various induction stations throughout the Nation estimate that 25 to 30 per cent of all men rejected for military service were rejected for some neuropsychiatric disability. In the Navy it has been found that about 20 per cent of all cases invalided out of the service were for neuropsychiatric causes.

While I was stationed in the Joint Services Induction Center in Detroit, Michigan, some questions occurred to me in connection with the psychiatric rejectees. How many of these men had had psychiatric treatment or had even been seen by a psychiatrist? Or perhaps were they treated by the family physician or others for their psychiatric disability? If so, what was the type of treatment received? The great majority of the men examined came from urban areas where psychiatric help was available. There were some, of course, from districts where psychiatric help was inaccessible or difficult to secure. Certain it was, however, that inaccessibility could not account for the small percentage of the total psychiatric cases having been seen by psychiatrists. To try to find out the reason, I took 140 consecutive cases, the rank and file of N-P rejectees, and questioned them as to the reason they had not had the benefit of psychiatric consultation or treatment. The psychiatric standards at the time of the sampling were not too rigid. The armed forces were badly in need of men, and mild neurotic trends were apt to be overlooked or passed as not disqualifying.

The examiners were pressed for time, and disqualifying personality traits which might have been uncovered by careful or more time-consuming examination often slipped through. These cases cited here were frank psychiatric cases, which even a cursory examination readily revealed to be psychiatric cripples.

In a recent investigation conducted on the need for and availability of psychiatric help for induction and armed forces rejectees, a great disparity was found between the need and available resources.[1] The disparity according to our investigation is only potential as long as physicians do not steer their patients into proper psychiatric channels for help or as long as patients are unwilling by reason of their ignorance or emotional bias, or unable for some other reason, to accept psychiatric help.

No doubt a much more balanced picture of the situation would be formulated if one had the opportunity to question the physicians to whom these rejectees went for help. For it would be naïve not to discount the patient's report of what the doctor said or had done for him. Everyone in practice knows of instances when his own supposed statements have come back to him secondhand in a very much garbled or fragmentary form, often torn out of context, resulting in a very much distorted meaning. Discounting all inaccuracies one can still make certain valid observations and detect certain trends from the reported statements of patients.

The most striking observation is the relative infrequency with which patients with psychiatric problems were referred to psychiatrists. Only 10 out of 140 patients made 1 or more visits to a psychiatrist, that is, less than 8 per cent. Many of them were not referred but sought out psychiatric help on their own initiative, usually those with some college background who had studied some psychology and understood the function of a psychiatrist. The infrequency of physician referrals becomes all the more remarkable when we consider that many of these patients, following one therapeutic failure after another, had been through the hands of several doctors. Some were actually discouraged from going for psychiatric help by physicians when they were told, as in the case of an epileptic, for example, that there was no help for their condition; or when told that psychiatric attempt at treatment might make their condition worse. Or, as in instances of enuresis, an attitude of complaisance was encouraged with the statement that for some people it's natural to wet the bed at night, and that in any event they will outgrow the weakness at puberty or later. Nor is it much more constructively helpful to tell a patient who is struggling with some psychoneurotic disability that "it's just your nerves." The patient had probably already come to the same conclusion himself, was discouraged in trying to cope with it, and the helplessness of medical science to do anything about his affliction may well have sent him into the ready hands of unorthodox practitioners who at least hold out some therapeutic hope, false as it may be. It is equally discouraging to the patient to be told that "it's your nerves and you've got to fight it yourself." If he would know how, he probably would not have gone to the doctor in the first place, and this statement is merely another way of putting the responsibility back in his own lap. To tell the patient to "forget about it," or to "learn to relax and not to worry," or even to change jobs, or to to go a different environment is apt to be hitting at the periphery and not at the core of the problem. At any rate, we can say that in these instances the physician recognized the existence of an intrinsic or personality problem, no matter how crudely he may have formulated it to the patient or how inadequate his management may have been.

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* Read before the Jacobi Medical Society, December 17, 1946.

In the majority of the formulations carried away by these patients, there was either an implied or more often an explicit statement that their condition was due to some organic derangement. The gastrointestinal tract, cardiovascular system, kidneys, lungs, and liver were most often made to carry the burden of their neurotic state. In keeping with the assumption of organic causation, dependence on diet, vitamins and various prescriptions naturally followed, with what poor results we can glean from the rejection rates of militarily eligible men.

It would be too presumptuous to claim that all of the minor psychiatric problems which came to the attention of the general practitioner should be referred to the psychiatrist. No doubt, many of the cases which have been helped by the family physician were not picked up by the screen of the induction examination. Many of the rank and file of the more benign psychiatric problems can and should be treated by the psychiatrically understanding family physician or general practitioner.

On the other hand, a great many of the cases cited here, perhaps nearly all of them, were so protracted or so severe that they required the help of a trained psychiatrist. The patients themselves would indicate that their doctor's treatment was of no value. Their "shopping around" and visiting several doctors would be an added indication. The question then naturally arises why they were not steered to a psychiatrist by the physicians who seemed impotent to help them. That it was not ignorance on the part of the medical profession can be verified when we note how alert physicians in the naval service were in referring patients for psychiatric consultation. In naval or military practice, of course, the patient-physician relationship is quite different than in civilian practice. There, the physician is a medical officer, who issues an order to the patient to go to the N-P service at 9 a.m. for consultation and that settles it. The civilian physician can issue orders also, but he has no assurance that the patient will carry them out or indeed that he will ever show up in his own office again. The civilian physician has to contend with and overcome all the ingrained prejudices and reluctance of the "mind-shy" patient and sometimes his own as well. Although facile psychiatric concepts and terms have become ultrafashionable in certain circles in recent years, the population-at-large is still woefully lacking in even elementary concepts of human behavior and its disorders, or the function of the psychiatrist in ministering to them. The patient does not feel offended or embarrassed when told that his stomach or kidney is impaired, but he is apt to shy away from any implication of his malfunctioning as an organism, or as the popular version has it, of his mind. If the untutored patient has any idea of what a psychiatrist is, he is apt to regard him as an eerie person, dealing with the victims of deranged minds, with whom he certainly does not want to identify himself or his symptoms. On the other hand, he feels more at ease if he is assured that his symptoms can be explained on a respectable somatic basis. His claim that psychiatric consultation is too expensive and he cannot afford it is merely a rationalization of his reluctance to have any traffic with a psychiatrist, or ignorance, for psychiatric fees are generally no higher than those of other specialists. "I put it off" or "I was afraid of what he might tell me, or what others might think of me" has its roots in the same emotional soil of prejudiced ignorance. Sometimes physicians themselves give tacit confirmation to these prejudiced feelings, or even encourage the patient's distorted belief about the function and range of psychiatry, when they tell the patient that there is no cure for his condition or that the psychiatrist might make him worse.

The imputation that the general practitioner discourages psychiatric visits because of economic motives, wishing to "hold on" to the patient himself, is not likely to stand up under scrutiny, since most physicians regard psychiatric patients as undesirable. They neither have the time, patience, nor the desire to listen to their many complaints or fine-spun stories and feel relieved in getting rid of them. That certainly was the usual experience in both the Naval Dispensary and Naval Hospital, where, to be sure, the economic motive did not play a role. If one did not find the same celerity on the part of the general practitioners in civilian practice, private conversation with physicians would usually bring out the point, that while they recognized the need of the patient to see a psychiatrist and were even anxious to refer him, they did not know how to go about it without embarrassing or offending the patient.

This probably is the crux of the problem. It is in this area of patient-physician relationship that the physician must feel an obligation not only to do what is expedient for the moment but what is in the patient's best interest in the long run. Medical schools nowadays should—and most do, much better than in the past—teach the physician a certain amount of psychiatric understanding and insight as it concerns not only the psychotic, but the ordinary run-of-the-mill, office practice cases. He must use this knowledge and be prepared to meet the challenge of his patient's prejudiced views and aversions about psychiatry. In his formulation of the patient's illness or complaints, he must do justice to emotional and personality factors as well as to the somatic involvements. To blame high blood pressure, irritable heart, or gastritis in an anxiety neurosis, and to let it go at that, is giving a distorted or fragmentary view of the total clinical picture. The physician must do justice to all the factors involved in a coherent diagnostic formulation. From this the next step, that of a need for psychiatric attention, would naturally suggest itself. A few well chosen words about the function of a psychiatrist as a specialist with medical training (which incidentally a great many lay persons do not know) would help to disarm his initial fears. To many lay people the phrase nerve specialist has a less ominous sound than the designation of psychiatrist, and there is no need of insistence on the latter term. The former has the added advantage of helping the patient to see and accept the need for going to a nerve specialist for a nervous disorder, if his condition has already been diagnosed as such. The physician would do well to explain to the patient that the psychiatrist, at least in private practice, is only concerned with the problem of the insane to a very minor extent and that most of his work deals with individuals suffering from emotional or personality problems, or nervous disorders such as no doubt the patient himself has.

A few telling examples, showing what effect emotional states have on body functions, would tend to desensitize the patient from regarding his symptoms as queer or based on some mental abnormality. The pounding of the heart, tremors and weakness in stage fright with its consequent rise of blood pressure; the blanching of the face and dilated pupils under fear; sleeplessness and loss of appetite from worry, are examples within the realms of man's everyday experience which the alert physician can put to good didactic use in enlarging the patient's psychologic horizon and pointing to the need for psychiatric help. Few doctors would be guilty of the brutally crude statement that "you're a nut and I am going to send you to a nut doctor," as one physician who had lost his patience was overheard to say. A negative attitude or acquiescence is not enough however. The physician must share the responsibility for public enlightenment along the lines of mental hygiene, even to a greater extent than other socially progressive elements in the community, precisely because of the nature of his work and the role he plays in the betterment of community health. If he accepts this obligation and does it well, there should be much less reproach directed at the medical profession in the future on the ground of the extent of neuropsychiatric ill health of our population and the profession's neglect or impotence in the face of it.

SUMMARY

1. A statistical sample of neuropsychiatric rejectees at an induction station is utilized showing what a small percentage of them had received psychiatric help.

2. From the diagnostic and treatment statement of the rejectees, the discerned trends and observations are discussed as to their failure to receive psychiatric assistance.

3. Finally, the method of referring and the obligation of the physician toward psychiatric cases is pointed out.

BIBLIOGRAPHY

1. Ginsburg, S. W.: Need and demand for psychiatric care among neuropsychiatric rejectees and dischargees; preliminary report for Committee on Psychiatric Needs in Rehabilitation (subcommittee of New York City Committee on Mental Hygiene). New York: Josiah Macy, Jr. Foundation, 565 Park Ave., 1944.

DIATHERMY MACHINES

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ALTHOUGH diathermy machines have been used for a number of years, there has been little attention paid by the users to the external radio effects which are inherent in their operation and use. New and proposed regulations by the U. S. Government to reduce the external radio interference of diathermy machines is a timely topic today.

Any radio transmitter has, as a basic part, a radio-frequency generator. A diathermy machine is a radio-frequency generator and uses vacuum tubes, resistors, condensers, wires, etc. It follows that a diathermy machine has characteristics similar to those possessed by a radio transmitter, such as power output, operating frequency, bandwidth and harmonics. All radio stations are licensed by the Federal Government and are required by law to operate within their licensed limits of power and frequency, and to cause no interference to other stations. Diathermy machines which were not regulated in the past are now subject to the same limitations as any other radio station. This will appear more reasonable if we examine the factors which affect radio receivers.

The power output of a radio transmitter largely determines the distance to which a signal can be received. The greater the power at the source, the further away the receiver can be and still hear the signal. The average radio station has a power output from 500 watts to 1,000 watts. It can be heard hundreds of miles away and under favorable conditions perhaps thousands of miles away. Diathermy machines on the average have a power output of 200 to 600 watts. There is some portion of the radio-frequency energy intended for the patient and which escapes into free space outside of the room and building. The amount which escapes depends on the particular machine and the specific modality being used. It is, as a rule, largest when the machine is turned on and no attachments are in use. Still, the amount need not be large for noise to be heard by a receiver within a 20-mile radius.

In a similar manner to a broadcasting station operating on a fixed frequency, i.e., 500 Kc (Kilocycles), a diathermy machine operates on a corresponding frequency. The older machines (long-wave type) operated at about 1,000 Kc or 1 Mc (megacycle) (300 meters). Later machines operated on higher frequencies of from 10 Mc to 100 Mc (30 meters to 3 meters). There are two other factors in diathermy machines which the commercial stations were compelled to correct many years ago. One was to operate on its frequency within close limits, and the other was to eliminate any radiation on higher frequencies or harmonics.

If a radio station is allocated an operating frequency of 1 Mc, it is necessary for technical reasons to allow a tolerance (usually about 0.1 per cent of the allocated frequency). This means that the operating frequency must never be higher than 1.001 Mc and never lower than 0.999 Mc. If it does so, it will be radiating in the frequency range of another licensed user and so cause interference to him. Diathermy machines (which up to recently have not been allocated a frequency) have in the past operated on a frequency determined by the physical characteristics of each machine, and it has been slightly different for each machine of the same type. A machine will change its frequency during use and also after aging. The total effect is a wide spread over a number of different frequencies, and consequently interference to a large number of licensed stations and receivers. It is true of not only the operating frequency but also the integral multiples of the operating frequency or harmonics.

If a diathermy machine is operating on 30 Mc (10 meters) the space radiation causing interference is on frequencies of 30 Mc, 60, 90, 120, 150, etc. These higher frequencies are the operating frequencies of Aviation, Police, Fire, Television, Frequency-Modulation, etc. In one large city, police radio receivers have been unusable for periods of 30 minutes at irregular intervals. Again, an Army Air Base has had to virtually stop operations when a diathermy 4 miles away was being used.

Interference, minimum useful signal and signal strength from the transmitter are all measured in units of "micro-volts per meter" abbreviated as uv/m. By test and experience it has been found that the desired signal must be at least ten times stronger than all other interference for the intelligence to be useful. If a police radio transmitter has a signal strength of 20 uv/m at a chosen location some distance from the station, the signal will be heard clearly, since the average police receiver will pick up a signal much weaker, say 1 uv/m. If a diathermy is then operated and its signal strength at the police receiver is over 2 uv/m, the police receiver will not be able to understand the communications from the police transmitter. A signal from the average diathermy machine is much higher than 2 uv/m and can be reduced only by complete metal shielding of the machine and patient, or by shielding the whole room as is done in England. A marked reduction can also be obtained by a new machine which has been designed with this purpose in view. A machine so designed must be tested completely to determine the actual amount of space radiations and the exact frequencies. This testing can and is being done by the U. S. Government, Federal Communications Commission, Washington, D. C.

The present F.C.C. regulations, which were issued in May 1945, require that all diathermy machines and other radio-frequency heating devices be operated on assigned frequencies and stay in the bandwidths listed below:

CENTER FREQUENCY	METERS APPROX.	BAND	
		Width	Tolerance %
13.66 Mc	22.	15 Kc	0.1
27.32	11.	270	1.0
40.98	7.3	40	0.1
(2450.00	—	100 Mc	Dec. 1946*)

* F.C.C. release, dated December 30, 1946, Sec. 301—F.C.A. 1934, Docket 6651, Part 18, F.C.C.

If a machine has a tendency to change frequency due to the particular load or to natural aging, and in so doing operates outside its authorized limits, the party being interfered with has just grounds for complaint to the F.C.C.

After receiving a complaint of interference and after tracing the interference to a particular machine the F.C.C. can order the interference to be stopped. This action can be enforced by due process of law if necessary. The F.C.C. maintains a network of monitoring stations for the purpose of seeing that all licensed radio stations are operated according to their allocations and do not cause interference. These monitoring stations can be used to locate transmitters which are operating illegally. To maintain order on the air and reduce harmonic intereference, the F.C.C. has found it necessary in the public interest to propose additional regulations for diathermy machines and other similar heating devices.

The presently proposed regulations (which are to be made final within the near future) are directed to the issues of license requirements, allowable harmonic interference, type-approval and grace period for old machines.

As stated before, all radio stations must have a license for legal operation. If the space radiation is less than 15 uv/m at 1,000 ft., no license is required. If the diathermy machine has been "type-approved" (see later) by the

F.C.C., no license is required. For operation within the allocated limits and without type-approval, an annual inspection by a competent engineer is required by the proposed regulations. The engineer will prepare a signed statement that the machine does meet the regulations and can reasonably be expected to remain in the same condition for the next year. In order to avoid annual inspections and licenses, there is the choice of either complete shielding of the room in which the machine is to be used or having a machine which has been type-approved.

Type-approval is a rating given to a specific type of machine which is to be made in production quantities. To avoid testing every machine, 1 machine is selected and given complete tests by the F.C.C. If the test results show that the machine is within stricter limits than the regulations allow, it is reasonable assurance that the machine variations due to manufacturing, shipping and use will not exceed the allowable limits. This procedure has been used by the radio manufacturers for many years. When the present proposed regulations are made final, the F.C.C. will be able to make the tests and give approval by issuing "type-approval." The manufacturer will state on the name-plate that this rating has been issued, and the buyer will have assurance that the machine will comply with all Federal regulations. The owner of a machine is responsible for its legal operation and not the manufacturer. Interference complaints require actions by the owner whether or not type-approval has been given.

Interference can be caused by the machine being outside its specified frequency or by harmonic radiation. Off-frequency operation is illegal by the regulations of May 1945. Harmonic interference will be understood more clearly by the following example. Assuming a police radio operating on 150 Mc and a diathermy machine on 30 Mc, the diathermy can radiate power on the 5th harmonic, which is the same frequency as the police radio. As a practical compromise, the F.C.C. has proposed that diathermy interference be kept to a limit of 25 uv/m at 1,000 ft. This corresponds to approximately 1 uv/m at 1 mile, and 1 uv/m is the weakest signal an average police radio will hear. To eliminate all interference would require complete shielding of the machine and would be very expensive for either old machines or new designs. Present interference is much higher than 25 uv/m since there are many machines which have been in service for a number of years. It is obvious that they cannot be stopped immediately.

Since the majority of existing machines were made before the War, the average age is about 7 or 8 years. Few machines were made during the War except for the services. When a machine is about 10 years old, even though it is working well, it should be carefully examined for both safety and possible major failure. All electrical equipment will age and depreciate over a period of years whether used or not. The F.C.C. has proposed that a grace period extending to May 1950 be used to allow old machines to depreciate before becoming obsolete or illegal. It is reasonable to assume that enforcement of present and proposed regulations will be directed mainly to the manufacture of new machines and to machines in use prior to May 1945.

It is my opinion that the proposed regulations will become final in the very near future and with little or no change from the proposed form.

In summary, the following points should be considered both as to public interest and self-economics.

1. Diathermy now causes serious radio interference.
2. The F.C.C. can stop an interfering machine from operating.
3. Interference can be stopped by complete shielding or by getting a machine which meets the new regulations.
4. The new regulations are in the public interest and safety. Doctors can coöperate

(*Continued on page 229*)

INTRACRANIAL CHOLESTEATOMA, EPIDERMOID OR PEARLY TUMOR

Report of a Case*

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CHOLESTEATOMAS[1] are rare tumors located on the median line of the calvarium, upper part of the corpus callosum, the choroid plexus, frontal and occipital bones, hypophysis, orbit and middle ear. There are two types, the true or primary and the false or secondary. Within the cranial vault and in direct relationship to the brain the primary type is more common, whereas in the mastoid region a preponderance of the secondary type is found.

Various theories have centered about the origin of the true cholesteatomas. Some authors believe they arise from endothelial cells which subsequently undergo necrosis, and others are inclined to consider them as mixed tumors arising from ectoderm. Two other forms of mixed tumors, situated in the brain and not to be confused with cholesteatomas, are those arising from three germ layers called teratomas, and those arising from two germ layers, ectoderm and mesoderm, referred to as dermoids. The three forms follow various courses and present different prognoses.

The true cholesteatomas, although the most common of the embryonic rest tumors, are rare. In general, they are localized, somewhat lobulated, and composed of a distinct pearly capsule surrounding an inner waxy-like lamellated substance, easily crushed and of soapy feel when rubbed between the fingers. Calcium and bone are often found in the capsule even though the origin may be extra-osseous. When they arise from bone, erosion is usually encountered. Histologically the capsule is composed of an outer fibrous layer called the stratum durum, a stratified squamous epithelial layer and an inner one of epithelial cells showing deeply stained, small granules.[2] The interior of these tumors may be composed of the so-called woody cells, having bizarre cell outlines but devoid of nuclei. Cholesterin crystals are also present, but not the hair or sebaceous material present in a dermoid. Ewing[3] describes these tumors as lamellated, waxy or scaly material in a wall of stratified squamous substance. In several of his own cases he found no evidence of any other than an epithelial origin.

In the mastoid and middle ear regions most of the cholesteatomas are of the false type resulting from prolonged, chronic inflammation; they are not infrequent. According to Gilmore and Urban,[4] a cholesteatoma in a mastoid process has been described as a circumscribed area of loss of bone substance extending from the mastoid antrum, having margins which are sclerotic, more so than may possibly be present in the surrounding bone substance.

REPORT OF CASE

The patient, J. H., a 33-year-old white salesman, entered the hospital, April 15, 1943, complaining of pain in the left occipital region. The family and past histories were irrelevant. About 2½ years before admission he first noticed pain in the left occipital region, coming at irregular intervals, lasting a few seconds at first with freedom of symptoms in the interim. The pain radiated down the left side of the neck posteriorly. Bending over, sneezing and coughing would aggravate the symptom or bring it on. A few months before admission he would awaken at night from the severe pain, which disappeared if he bent his head forward and to the right and held it in that position for a minute or two. About 3 months before admission he noticed a soft swelling in the left occipital region, which he stated increased in size when the pain got worse. He complained of no other symptoms. There was no history of vertigo, vomiting, diplopia, loss of vision, or weight loss.

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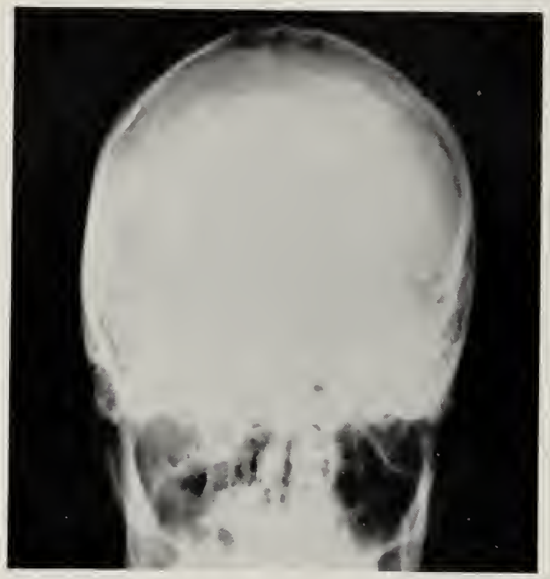

Fig. 1. AP projection of skull showing the transverse calcific plaque located at level of left internal occipital ridge.

Physical examination revealed a well nourished and developed 33-year-old white man in no apparent distress and in good general condition. There was a soft, nontender mass about 3.5 cm. in diameter in the mid-left occipital region. It felt cystic, was not movable, and had an underlying bony defect, easily felt. Pulsations were not present. The pupils reacted to light and accommodation, and one observer noted paling of the right disc with blurring of the edges; small hemorrhages were noted and the veins were tortuous; the left fundus was similar except that no hemorrhages were seen. Hearing was good. The blood pressure was 120/80; respiration and temperature were normal; the pulse rate varied from 60 to 133. The remainder of the physical examination was negative. Psychiatrically he was also intact, except that his mother stated that since his present illness he easily forgot dates and addresses.

Laboratory data consisted of normal blood counts and differentials; negative Kahn and Wassermann tests; blood nonprotein nitrogen 27.5 mg. per 100 c.c. and uric acid 3.7 mg.; urinalyses normal with specific gravity as high as 1.025; sputum examinations negative; B.M.R. plus 2 per cent; spinal tap not done.

Roentgenograms of the skull revealed a large oval defect in the left side of the occipital bone, extending to the lambdoid suture, measuring 8 x 4 x 4 cm. The edges were fairly well defined. A transverse calcific plaque was noted in the region of the internal occipital ridge. The basiocciput showed erosion of the outer table with several calcific strands extending into the adjacent soft tissue. There was no change of the sella turcica, and a calcified pineal body was present in the midline (figures 1 and 2).

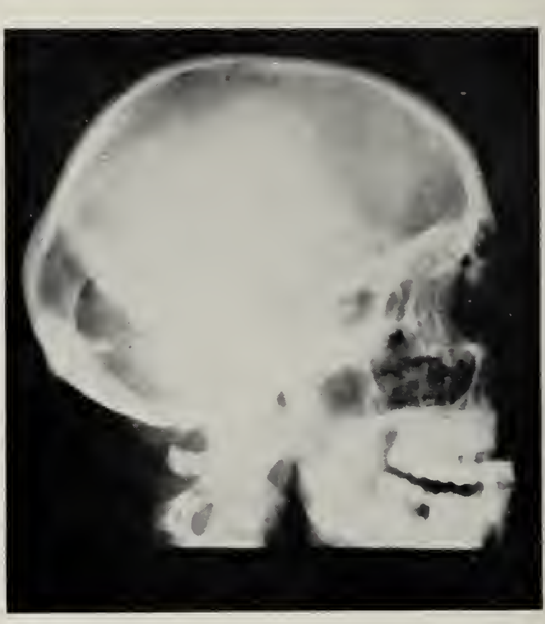

Fig. 2. Left lateral roentgenogram of skull, revealing an oval defect in the occipital bone measuring 8 x 4 x 4 cm. Anteriorly it reaches to the lambdoid suture. Inferiorly at the base of the occiput it extends into the adjacent soft tissue in the form of several calcific strands. The borders of the bony defect are fairly well defined.

On his 19th hospital day a craniotomy was done by Dr. H. H. Kerr, surgical consultant, with the following notation: At operation, a horseshoe-shaped incision was made over the tumor in the left occipital region and the dissection carried down to the bone. When this was dissected free, it was found to border a cystic-like mass apparently larger intracranially than extracranially. Some of the bone was rongeured away and dissection carried down exposing a huge cystic growth. The capsule was entered, and cheesy, flaky-like material was scooped out until the whole tumor contents were evacuated. It was then seen that the tumor was extradural, extending over to the mastoid, down below the transverse sinus, well into the posterior fossa, and across the midline halfway to the opposite mastoid. When the contents were completely evacuated a rather thin lining membrane was picked up, dissected from the bone and from the dura. Apparently the entire tumor with its capsule was removed. The wound was thoroughly flushed out with sterile salt solution and the flap, muscle and integument sutured back in position with cotton and without a drain. He was discharged 9 days later as cured.

The specimen received in the laboratory consisted of very many waxy and cheesy plaques having the luster of pearl and easily crushed between the fingers with a consistency of soap. Irregular spicules of calcium and bone were present. The entire contents of the tumor loosely occupied a 60 c.c. specimen bottle. A few drops of chloroform mixed with a small fragment of substance turned it a yellowish green, an excellent test to show the presence of cholestrin. Microscopically, the capsule consisted of an epidermoid epithelium and an inner substance of oblique blocks, well outlined but devoid of nuclei.

In the case presented, the tumor arose from one of its least common locations, the occipital bone, and caused only slight objective signs of increased intercranial pressure, manifested by vague fundal changes. There were no neurologic signs as might have been anticipated by the size of the mass, but the bone erosion produced probably was of sufficient degree to have relieved most of the intracranial pressure. There were a number of features of value in preoperative diagnosis: the age of the patient, most of these tumors occurring in young adults; the normal red and white blood cell counts; and the distinct bone erosion with calcific strands extending into the soft tissue.

BIBLIOGRAPHY

1. Stengel, A., and Fox, H.: Textbook of Pathology, 8th ed. Philadelphia: Saunders, 1927, pp. 974, 1014, 1081.
2. Baker, A. B.: Outline of Neuropathology, 2nd ed. Minneapolis: Univ. Minnesota Press, 1941, p. 25.
3. Ewing, J.: Neoplastic Diseases, 4th ed. Philadelphia: Saunders, 1942, pp. 1021, 1061.
4. Gilmore, J. H., and Urban, L. D.: Roentgenographic considerations of some aspects of chronic mastoiditis with special reference to cholesteatoma. Illinois M. J., 1941, **80,** 153.

CLINICO-PATHOLOGIC CONFERENCE*

The George Washington University School of Medicine

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Case History

A 48-year-old colored male, admitted December 18, died January 29.

Chief Complaint: Dyspnea, chest pain and hemoptysis.

Present Illness: Four months before admission, the patient stopped work as a general laborer because of an intermittent aching pain in the left side, radiating to the lumbar region of the back. Three weeks before admission a "chest cold" developed associated with an increase of the pain. These symptoms, plus some shortness of breath, increased steadily up to admission. During the present illness there has been moderate fever and there have been occasional night sweats. The patient has had a chronic cough with expectoration, associated with 8 to 9 attacks of hemoptysis in the past 9 months.

Family History: Non-contributory.

Past History: Mumps 9 years before followed by "inflammatory rheumatism" affecting the right side, due to which the patient was "unable to move and was in bed for a week." No history of cardiorespiratory, gastrointestinal or genitourinary disease. Patient thought he had lost weight shortly before admission.

Physical Examination: B. P. 115/80, pulse 90, respiration 26, temperature 99°F. The patient was a moderately underweight, middle-aged colored male, evidently in some discomfort.

Head: Eyes—pupils react to light and accommodation, extra ocular movements normal, conjunctivae of good color. Ears—not abnormal. Nose—not abnormal. Mouth—teeth in fair condition, gums spongy, tonsils and posterior pharyngeal wall inflamed.

Neck: Normal.

Chest: There is a slight limitation of excursion on the left. "The breath sounds are exaggerated on the right and also at the left apex." (One examiner thought there was amphoric breathing in the left apex.) On descending the chest posteriorly, breath sounds disappear completely at the angle of the (left) scapula or just above. Vocal fremitus and resonance disappear at the same level. There is flatness to percussion in the left mid-chest posteriorly. Coarse râles are heard in the left apex. No abnormalities noted in right lung.

Heart: Apex beat seen 5 cm. to left of midsternal line in 6th interspace. There is a diffuse cardiac impulse palpable over the entire anterior chest wall. The right border of the heart is 3 cm. to the right of the midsternal line in the 6th interspace. A loud systolic murmur is heard over the mitral area.

Abdomen: Liver, spleen and kidneys not palpable. No muscle spasm or tenderness or masses noted.

Extremities: Not abnormal.

Neurological: Biceps, triceps and knee jerks sluggish. Suggestive Babinski of both feet.

Laboratory Examination: Blood: 12/19 Kahn 4+; hemoglobin 80 per cent; white cell count 7,000; polymorphonuclears 63 per cent; lymphocytes 36 per cent; monocytes 1 per cent.

Urine: 12/21—amber, acid, sp. gr. 1.032, albumin negative, sugar negative. Microscopic, occasional white cell. Urine from right and left kidneys 1/11—direct smear: no organisms, no tubercle bacilli.

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* This presentation is one of a series of weekly Clinico-Pathologic Conferences conducted at the George Washington University School of Medicine, Washington, D. C. Mimeographed abstracts of the cases presented including the essential symptoms, physical findings and laboratory results are distributed to all members of the faculty and students at the beginning of each week. The final diagnosis, which is discussed at the conclusion of the Conference, is known only to the pathologist.

X-RAY EXAMINATION: 12/21—P-A of chest shows circumscribed area of increased density involving middle of left lung field. The left base and left apex and entire right lung are relatively clear. Considerable displacement of heart to right. 12/22—"Right lateral—shows lesion previously reported to be in the middle of the left lung field." Flat plate of the abdomen, cystocopic examination and pyelography revealed no abnormality of the genitourinary tract.

HOSPITAL COURSE: The temperature ranged from 97° to 101.2°F., averaging 98.6°F. with usually an afternoon rise to 99°–100°F. Pulse and respirations were normal. An aspirating needle was inserted in the left chest posteriorly on 1/9. About 100 c.c. of clear, straw-colored fluid was withdrawn. No organisms were found on direct smear or on culture. No tubercle bacilli were found. The patient did not complain of pain and seemed to be improving gradually. He was up and about the ward until the morning of the terminal day, when he complained of not feeling well. At noon he began gasping for breath, and died 15 minutes later.

CLINICAL DISCUSSION

SENIOR LYONS: This case impresses me as one of bronchogenic carcinoma. He was a middle-aged man whose chief complaint was weakness, dyspnea, cough and repeated attacks of hemoptysis. Such symptoms also are most suggestive of pulmonary tuberculosis; however, against this is the fact that no tubercle bacilli were ever found. He was in the age group also for carcinoma of the lung and in addition to this, the X-ray films of the chest showed an infiltration in the left lung field which impressed me more of being a tumor than that of tuberculous infiltration. Two of the most common causes of repeated attacks of hemoptysis are tuberculosis and cancer of the lung, and I am always suspicious of the latter when the sputum fails to show the organism. I note also in the examination of the heart that he had a loud systolic murmur over the mitral area. This probably represents a stenosis which in itself alone often causes hemoptysis and may lead to sudden death. While several conditions could have caused this man's symptoms, I feel that the weight of the evidence points more toward cancer of the lung.

SENIOR MANKIN: I am of the opinion that this man had an aneurysm of the aorta. It is noted in the X-ray films that while there was increased density in the middle of the left lung field, which may have resulted from several conditions, there was also marked displacement of the heart to the right. Something pushed it over and I think this was an aneurysm. Again to substantiate this conclusion, it is noted that he had a 4+ serology with no mention of antiluetic treatment. I should like to know whether or not there was pulsation over the area noted. The protocol does not mention this but it does say that there was flatness to percussion posteriorly, associated with a diffuse cardiac impulse palpable over the entire anterior chest wall.

DR. BLOEDORN: Did you consider any other possibilities?

SENIOR MANKIN: Not seriously. I thought of bronchogenic carcinoma as a possibility but dismissed this as I do not believe such a lesion involving the left chest would displace the heart to the right. Then again the incidence of thoracic aneurysm and 4+ Kahn is greater than that of lung cancer.

SENIOR CHOISSER: Here we have a middle-aged colored man complaining of weakness, loss of weight and hemoptysis extending over a period of 9 months. An X-ray film of the chest showed an area of increased density in the left lung. The two most common conditions that cause such symptoms and physical findings are carcinoma of the lung and tuberculosis. I considered an aneurysm but ruled it out because it is difficult for me to see how an aneurysm could bleed slowly for almost a year before rupturing. Carcinoma of the lung is on the increase and should be suspected in all cases of dyspnea, weight loss, and hemoptysis in which sputum examinations fail to reveal the organism. In both pulmonary tuberculosis and lung cancer, hydrothorax is common. In cancer it is more often bloody. Here the fluid was clear and the laboratory was unable to find tubercle bacilli, which I believe they would have if the lesion had been tuberculous. Another thing against tuberculosis is the fact that the patient was up and about the ward on the day of his death, and I do not think a person dying of tuberculosis would be ambulatory 15 minutes before death.

DR. BLOEDORN: You have a good point there. The patient apparently was improving and was up and about the ward and began gasping for breath and died in 15 minutes. What do you think happened? What are some of the causes of sudden death?

SENIOR CHOISSER: Hemorrhage, cerebral accident, coronary occlusion and pulmonary embolism are the most common. Erosion of a large blood vessel by the cancerous growth could well have been the terminal event.

SENIOR PRITCHARD: I thought of several possible diagnoses including aneurysm, carcinoma of the lung, and pulmonary tuberculosis. I don't believe there is enough data given to say absolutely which was the cause. I favored, however, bronchogenic carcinoma.

JUNIOR GLEW: I had a difficult time arriving at a diagnosis. My first impression was pulmonary tuberculosis. I ruled this out, however, on several points. First, no organisms were ever isolated; second, the X-ray film of the lung was not consistent with tuberculosis; third, the hemogram should not have been so near normal in the terminal stages of tuberculosis, and, as Choisser said, if it were tuberculosis, the patient would not have been up and about the ward 15 minutes before death. I favored syphilis of the lung basing this on the 4+ serology, X-ray findings and sudden death. I know this is rare, yet Tice mentions at least 20 cases.

DR. BLOEDORN: This case was not an easy case to decide on. The three most likely diagnoses, as indicated by your conclusions on this case were: (1) bronchogenic carcinoma; (2) pulmonary tuberculosis; (3) aneurysm of the thoracic aorta. Now, first, pulmonary tuberculosis—certainly the history was most suggestive. There are a few things against it. I assume that the sputum was examined in this case; certainly the patient wouldn't have been in the hospital 6 weeks with hemoptysis, cough and expectoration without a careful examination of the sputum. There was no record of a positive sputum. The X-ray film of the chest of the average case of pulmonary tuberculosis, at this stage of the game, is fairly characteristic, in fact, in most instances, unmistakable. Tuberculosis can do peculiar things and you have unusual lesions which show up, but the only report we have from the X-ray Department is that this patient had an area in the center of the left lung of increased density. Over this area there were dullness and absent voice sounds. This question of fluid so strongly impressed the clinician that a paracentesis of the chest was done and 100 c.c. of clear, straw-colored fluid removed. Now, this was searched for the tubercle bacillus with negative results.

Another diagnosis favored, bronchogenic carcinoma, had probably a few more adherents. Again the history is very suggestive: hemoptysis, cough, pain and loss of weight. It is peculiar to see how a patient would remain in a hospital for 6 weeks, if bronchogenic carcinoma had been strongly suspected, without any attempt at a bronchoscopic examination. As a rule, the physician as well as the patient wants to establish the diagnosis as soon as possible. The bronchoscopic examination is a relatively safe procedure unless there is some specific contraindication to it, and there are a few. It is difficult to see why an attempt wasn't made to obtain a biopsy through the bronchoscope.

The question of aneurysm of the aorta has been raised and strongly supported. What favors an aneurysm? This patient had a 4+ Kahn. There is no history of treatment for syphilis. You know most cases of aneurysm that we find now are cases of syphilis that have been poorly treated or absolutely untreated. In other words, treatment of aneurysm now is the treatment of syphilis. Syphilis, adequately treated at the outset, is your best guarantee against aneurysm. As the result of active, efficient and early treatment of syphilis, the incidence of aneurysm is almost nil. Here is a patient who, if he did have syphilis, evidently had no treatment for it. The thing that is a little confusing about this case is the X-ray report. If this were an aneurysm of the thoracic aorta, there should be presumptive evidence of it on the X-ray plate. The X-ray together with fluoroscopic examination is pretty accurate in determining the presence of an aneurysm. There was a mass that occupied the center of the left chest. If this mass were just out there by itself, of course it couldn't very well be an aneurysm. Some of us arrived at that conclusion, that this was a circumscribed mass either in the interlobar area or somewhere in the lung. If that was the case, if it was entirely separated from the mediastinum, you'd have a hard time diagnosing an aneurysm. If this mass were continuous with the mediastinal shadow, and I assume that it was, I don't see how aneurysm might not supply the answer, in view of his sudden death. He was up and about the ward, and died in fifteen minutes.

In the case of bronchogenic carcinoma, we presume that if a vessel were ruptured, the bleeding would be into the bronchus and a sudden gush of blood would spell the end. The aneurysm might also rupture into the pleura or the mediastinum, in which case no blood would appear externally. I would favor aneurysm.

Report of Necropsy

Dr. Choisser: This case, as you see, was a real diagnostic problem and was seen by quite a few consultants. The following diagnoses were recorded: (1) luetic heart disease; (2) pulmonary tuberculosis; (3) ruptured encysted effusion with pleural shock. Bronchogenic carcinoma was not considered in this case at any time by any of the consultants. At autopsy, this man was well developed, rather poorly nourished, and showed nothing unusual on gross inspection. Upon exposure of the viscera, there was some distortion of the general relationship of the organs due to a massive left pleural effusion. There was no fluid in the abdominal cavity, no jaundice or edema, but there was generalized lymphadenopathy. Examination of the gastrointestinal tract showed no gross pathologic lesions. The liver was somewhat enlarged, rather firm, but revealed no evidence of cirrhosis, abscesses, or of malignancy. The kidneys were in the usual position, surrounded by the usual amount of fat and revealed nothing on gross inspection other than early nephrosclerosis. No tumors were evident. The ureters were not dilated and the bladder contained a normal amount of urine. The walls were not trabeculated or thickened and there was no enlargement of the prostate. The entire abdominal cavity was practically negative so far as gross appearances were concerned. The entire pathology apparently lay in the left pleural cavity. The right lung was about normal in size, and there was no increase in fluid in the right pleural cavity. Upon palpation of the mediastinum, a large tumor mass was felt. The heart was removed and it was about normal in size; there was no evidence of valvular lesion, or evidence of coronary sclerosis. After the heart had been removed, this large, firm tumor mass, which was densely adherent to the vertebra, was removed. It was found to be a large aneurysm which was laminated and showed a small rupture in the upper posterior portion. It was not a complete rupture resulting in a sudden gush of blood into the pleural cavity, but caused a slow leak that had filled the left pleural cavity with blood. The blood had settled in the lower portion and had coagulated. The top portion that was drawn off by paracentesis was nothing more than plain serum. The anatomic diagnosis was:

1. Rupture of an aneurysm of the thoracic aorta with left hemothorax.
2. Cardiovascular renal disease.
3. Mild generalized arteriosclerosis.
4. Terminal exsanguination.

President's Page

ANESTHESIA

It is a far cry from the days of drop-ether and chloroform to modern anesthesia. Today the trained anesthetist must have a profound comprehension of physiology, biochemistry, therapeutics and medicine in their broadest and most complex sense. He must also have an understanding of all known factors concerning reversible and irreversible shock. In addition to this, he must be capable of handling complicated mechanical equipment of various kinds with deftness and facility.

Ignorance of the fact that asthmatics may die as a result of administration of spinal anesthesia is an example of the necessity of having physicians who know what they are doing supervise the administration of anesthesia, or administer it themselves. Nowhere in medicine is consultation more valuable than in the determination of the type of anesthesia best suited to a case which is known to involve serious risk.

It should give members of the Medical Society a sense of security as well as satisfaction to learn that our organization has before it an amendment to its Constitution and By-laws creating a Section on Anesthesiology, thus giving this specialty the position of importance which it so well deserves. It is also comforting to know that among Washington's anesthetists are leaders who have done much to raise the standards in their field. We are proud of their achievements and that we can claim them as our own.

William P Herbst Jr

Editorials

AS A NEWSPAPER REPORTER SEES IT*

For a newspaper reporter, even one devoted chiefly to coverage of medical science stories, to be given the opportunity of "talking back" to the doctor, as it were, is a rare and welcome privilege. Not that the opportunity will be exploited as an outlet for pent-up complaints. Quite the contrary. It might have been so as recently as ten years ago. But there has been such steady improvement in relations between medicine and the press that this little essay could far more easily be turned into a paean than a diatribe.

The M.D. no longer looks upon the newspaper's medical story as an unnecessary evil. He appreciates that the lay public has a legitimate interest in, and concern with, a new antibiotic which arrests infection and a surgical technic which lengthens the cancer patient's life. He welcomes news writers to his professional meetings and patiently explains the significance of abstruse papers. The wisdom of this policy, which stands in marked contrast to the feeling of mutual suspicion a few years ago, is reflected in the mounting quality of news and feature stories on medical subjects appearing in the press.

This evolutionary progress has taken care of the important problems so well that even a seeker after perfection, trying to point out the last remaining flaws, must strain somewhat as far as showing the doctor how to heal himself is concerned. Less exertion will be needed when the subject of self-cleansing by the newspapers is raised presently.

With respect to those "last remaining flaws," they come to mind in the following order: (1) Doctors (indeed, practically all scientists) continue to be dilatory in equipping themselves with extra copies of papers which they are presenting at professional meetings; better yet, they should send such copies—for the convenience of the press—to the host organization well in advance of delivery; (2) some raise an eyebrow when they see a news story mentioning or quoting a physician, their impulsive conclusion being that the doctor is a publicity-hunter; in all probability, the press notice was not only unsolicited but the circumstances completely justified the use of his name without compromising ethics one whit; (3) all physicians, and not just the comparatively small number who have frequent dealings with the press, should make a sincere attempt to understand that newspapers' interest in medical stories does not begin and end with the spectacular or sensational; rather, they are on the alert for items and features which, accurately and interestingly composed, will inform—maybe even educate—the reader. True, the story may be spectacular but there is nothing intrinsically wrong with that, so long as it is not guilty of bad taste and does not contain any misinformation, particularly dangerous misinformation.

Now what about the newspapers? No one can deny that their handling of health and medical stories is superior in every respect—accuracy, discrimination in selection of material, care in securing confirmation of reports, reader interest and every other—to the hit-or-miss, systemless system which was in vogue well within the memory of middle-aged practitioners. But has it reached the pinnacle? It has not.

Your daily newspaper—and let's include the wire services in this, too, for these syndicates are really the chief culprits—is still a pushover for the neurotic publicity-seeker who says he'll sell a perfectly good eye so that the daughter may go to finishing school or the landlord may be paid next month's rent.

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* This is the fourteenth in a series of guest editorials by distinguished physicians and laymen.

Your daily newspaper (along with the wire services) continues to overdo stories of the tear-jerker, sob-sister variety, about children suffering from hopeless conditions. Leukemia is a favorite.

Another fault lies in the tendency, noticed frequently in some papers and less commonly or almost never in others, to be just a wee bit too sanguine, too enthusiastic in reporting something new, say, an artificial limb which is purportedly an improvement or a drug which appears to immunize mice against cancer.

There are other shortcomings, of course. You doctors could compile a long list of them, no doubt. Fact is, it might be a good idea to do so and furnish such a list to the reconstituted Public Relations Committee of the Society, to be employed as ammunition in a battle royal with the Capital's city editors and medical writers. So far it has been all take and no give, where the Public Relations Committee is concerned.

Let there be more give and take on both sides. It will be healthful all around—for medicine, for the press and, most important, for the public.

Gerald G. Gross
The Washington Post

THE DISTRIBUTION OF ANESTHESIA

Over the whole field of medicine there is a wide gap between what the best men know how to give and what the average patient receives. In no other specialty is this separation so wide as in anesthesiology.

The most important factor in this serious situation is the shortage of trained physicians. There is only one certified anesthesiologist for every twenty approved hospitals in the United States. Contributing factors are that for so long physicians had no appreciation for or interest in anesthesia, and that the traditional way in which nurse anesthesia existed gave hospitals a financial stake they hated to give up. The former backwardness of surgeons to claim what anesthesiology has to offer is now a rapidly diminishing influence.

Since this problem is becoming clear-cut the solution to it is likewise apparent though complex.

The personnel shortage can be made up in part by the stricter organization of departments to use to best advantage the help available. This requires that the proper functions of an anesthesia service be recognized to be as follows:

1. Administration of anesthesia, surgical and obstetrical.
2. Administration of a pre- and postoperative routine with special reference to the use of depressant medication; the supervision of a recovery room where all unconscious patients may be watched by trained personnel.
3. Supervision of gas therapy and resuscitation.
4. Supervision of intravenous therapy especially in the operating room.
5. Diagnostic and therapeutic nerve blocks.
6. Teaching nurses, medical students, internes and the medical staff.
7. Administrative control of the operating room and sterilization for the hospital.
8. Research, both clinical and laboratory.

The smallest hospital can go part way through this list and should always aim to go further. The larger one should place responsibility in the hands of a trained physician to administer if possible all of these functions.

In this necessary organizational effort the medical profession and the hospitals should resist strongly the inevitable tendency to close most anesthesia staffs. A closed staff in a university hospital may be desirable and even necessary. To have it in all hospitals of a community would lead to the stagnation of that area by the throttling of all incoming competition. Furthermore, it would lead to a degree of institutional control over anesthesia which might ultimately sterilize it of all competent physicians.

The effort to achieve such an organizational pattern should not be resisted by nurse anesthetists. Under the law they must work under physician direction. How much better for them to be directed in anesthesia by competent anesthesiologists than by surgeons relatively untrained in anesthesia! There is room for the nurse anesthetist in a well-run department.

In the necessary enlargement of the anesthesiologist group there are several important factors. Financial return must be adequate to attract the most competent specialists; professional prestige must be equal to that of other specialties; first-class training opportunities must be made more extensively available.

The steps then which must be taken to make the best anesthesia generally available at the earliest moment may be summarized as follows:

1. A clear organizational plan must be followed, with the most competent personnel in supervisory and teaching positions.

2. More active aid of organized surgical groups is needed to support institutional education in the field of anesthesia.

3. The AMA, under pressure of local societies, must require that anesthesia in approved hospitals be under the direction of physicians who are anesthetists in fact. The naming as head of anesthesia some staff physician who does no anesthesia is a pretense at standards which do not exist, but should.

4. All anesthesia services should be run on a teaching basis. This will react to the great good of the institution and will enlarge the group of trained anesthetists in the shortest time.

5. Every medical school should set up anesthesiology as a department under a full professor directing pre-clinical and clinical teaching in this complex specialty. The university hospital service should approach the ideal setup. The profession must become alive to the fact that some centers holding high general standing are woefully behind the times in anesthesia. These institutions especially must improve because of the important example they set.

The handwriting is on the wall. Even the lay public will soon demand a wider distribution of good anesthesia.

D. S.

THE MEDICAL STAFF OF THE HOSPITAL

A certain amount of confusion exists in the minds of many physicians concerning their relation to the hospital, particularly in reference to their privileges and responsibilities. The layman probably has a vague but somewhat exalted opinion of the doctor's status when he, the doctor, states, "I am on the staff of Blank Hospital." It is not surprising that misapprehension occurs when the subject of hospital appointments is approached from the point of privileges and responsibilities.

For the purpose of classification it would be timely to survey the subject.

Teaching institutions or university hospitals carry over automatically from the medical school most members of the clinical faculty as members of the staff, and in this respect differ from the run-of-the-mill hospital. In the voluntary or community hospital, which is rarely closed, the appointing power is usually vested in a Board of Directors who act upon the recommendations of its active staff. It is not conducive to the best interest of the hospital to leave the appointments to a board which is dominated by politics or has a voting majority of laymen whose interests are confined to occasional perfunctory visits to the institution. A better arrangement is to establish a governing board, called trustees or directors or governors, of which a majority are physicians who show an active interest in the hospital. The staffs of the hospital should be divided as follows:

The Executive and Teaching Staff
The Consulting Staff
The Courtesy Staff
The Honorary Staff

The Executive and Teaching Staff should be the appellation of what is commonly called the visiting staff or the attending staff. It is THE staff about which most of the medical activities revolve. Before being appointed or elected to the staff, the member should file his qualifications with the administrator of the hospital. The members of this staff not only have the privilege of treating private cases but often are assigned to charity or semi-charity cases. Upon this group rests the responsibility of maintaining the high standard of the hospital, and this entails many duties other than attendance upon the patients under their care. There are records to be inspected, internes to instruct, scientific meetings to arrange, to mention a few of their additional chores. All of these duties require an expenditure of energy and time. The standing of the hospital in the eyes of the community is largely reflected in the zeal, high motives, and efficiency of the members of the Executive and Teaching Staff. It will always be true that a hospital will be as good as its staff and no amount of masonry or ornamentation will be a satisfactory substitute.

The Courtesy Staff consists of that group of physicians who are permitted to send patients into the hospital and treat them as private cases. To obtain these privileges they are expected to apply in writing and supply adequate information concerning their professional qualifications, citizenship, and society membership, and to submit letters attesting to their professional standing and moral character. Their obligations in so far as the hospital is concerned are limited to observing the practices of the hospital and furnishing their patients adequate and competent service. Physicians by courtesy take no part in formulating policies or rules of the hospital. They are in no sense agents or representatives of the institution. As the name implies, these physicians are extended the courtesy of the hospital. In some vicinities they are known as attending physicians, but this designation should be abandoned as practically all physicians are "attending."

Another classification is that of Consultant and embraces those physicians whose practices are largely confined to a consulting nature, but when the occasion arises, they are permitted to have patients admitted for their care. Like the courtesy staff, they do not participate in the general activities of the hospital; but like the courtesy staff, they are welcome visitors at all scientific meetings. They are usually approved by the board without the formality of an application as their standing in the community is well established.

The last group, Honorary members, is confined to that small number of physicians who have distinguished themselves in some field of medicine. The hospital invites them to become members of its staff in recognition of their outstanding achievements. It is the greatest tribute that the hospital as an institution can offer.

The methods of electing or appointing various classes of staff members vary somewhat, but in general these are the methods employed:

Committees of the Executive Staff are appointed by the board to review the applications in the various specialties in medicine and all applications pass through their hands after the applications in proper form are read at a meeting of the staff. At the next regular meeting of the staff or Board of Governors the committee submits its report with recommendations, and the staff or board takes appropriate action. It is the privilege of any member of the board to express approval or disapproval of any applicant and to ask for postponement of action pending further investigation.

This practice or a very similar one is employed in most American hospitals, unless they are privately operated, and seems to be a democratic and eminently fair one. Some skullduggery creeps in occasionally, however, much to the detriment of the institution involved.

C. S. W.

JUVENILE DELINQUENCY

The National Conference on Prevention and Control of Juvenile Delinquency was called by the Attorney General of the United States to meet in Washington on November 20, 21 and 22, 1946. More than 800 representatives of Federal agencies, state and local governments, and private welfare groups were in attendance. This meeting was the result of a previous meeting of an Advisory Panel selected by the Attorney General. This group of 800 was divided into some fifteen panels for the study of various phases of the cause and prevention of delinquency. Their reports and recommendations were presented and adopted at a general session of the Conference. The panels represented such groups as: Community Coordination, Institutional Treatment, Juvenile Courts, Police, Recreation, Youth Participation, Church Responsibilities, Schools and Teachers, Home Responsibility, Mental Health and Child Guidance Clinics, etc., etc.

A Continuing Committee was formed at the conclusion of the Conference for the purpose of integrating the recommendations of the various panels and activating existing agencies having to do with juvenile delinquents. Also this Committee is charged with dissemination of information not only to organizations and agencies, but to parents and all members of society interested in this problem. They will help to organize and plan activity through the press, radio, clubs, schools, etc. They will assist in fostering Federal, state or local legislation for the establishment of necessary laws, institutions and boards leading to better care, prevention and rehabilitation of delinquents.

This Conference was precipitated by the reports of Mr. J. Edgar Hoover on crime in the United States. His report showed a definite lowering of the age level for both male and female offenders. These facts had been noted by the President of the United States and he gave his wholehearted endorsement to the Conference. In addition to the Hoover reports, Mr. Clark found that there were some 1,500 delinquents under the direct care of the Department of Justice.

In many of the panel reports the medical profession is called upon for specific activity in the program. In the report of the Panel on Institutional Treatment of Delinquent Juveniles the following paragraph appears:

> RESPONSIBILITIES OF MEDICAL OFFICERS
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> The medical officer must realize that there are many physical defects among the children committed to his care. He must see his job as comprising the correction of such defects as well as the inculcation of good habits of health. Mental health is an integral component of physical well-being, and to this end he must lend the services of the psychiatrist and the psychologist with something more than the purely diagnostic in mind. This implies an emphasis on therapy whether it be in the emotional or in the surgical sphere.

Again in Juvenile Court Administration the following recommendation is made:

> Provision for social study prior to court hearing, which includes study of the child himself, his physical, mental, and emotional development; study of his environment, including his family and home conditions, and associates; an estimate of the essential causal factors responsible for his behavior; and in the light of this estimate recommendations for treatment.

In the field of the Mental Health and Child-Guidance Clinics the physician is called upon for his most specific contribution. "It is the business of the guidance clinic to study the delinquent's particular physical, mental, and emotional functioning and to discover what influences in his environment he is reacting to by delinquency." "The bases for socialized behavior are laid in childhood, the 'golden period' of mental hygiene"—the period when a large percentage of children are brought to the physician for physical care as well as for incipient behavior disorders. Our great opportunity lies here—in the prevention of gross misbehavior. Dissemination of knowledge of mental health principles "will go far to reduce the legally recognized type of maladjustment that we label 'Juvenile Delinquency.'" Both the U.S.P.H.S. and the National Institute of Mental Health are deeply interested in encouraging research, training personnel, and aiding community programs in this field.

It would appear that the greatest contribution the physician can make is to acquaint himself with normal physical, mental and emotional development of children. With this knowledge he can advise individual parents in the proper upbringing and discipline of children through the "golden period." As in all problems of human behavior, be it physical or emotional, prevention is the keynote. In recent years we have learned that the groundwork of maladjustments is laid in early childhood. Therefore, it is not unlikely that in marriage itself is planted the seed of a normal family unit. Certainly with the birth of the first child, adjustments are made and relationships are formed which determine future patterns of behavior.

P. A. McLendon, M.D.

In and Out of Focus

BY THE OBSERVER

Washington—A Medical Center

There is every reason why Washington should be a national, if not a world, medical center. That is the view taken not only by your Observer, but by many physicians with whom he has talked in recent weeks. What brought this to mind at this time was a news report which appeared in the *New York Times* for March 7, announcing a plan to make New York "the medical capital of the world." The plan was outlined by Dr. George Baehr, President of the New York Academy of Medicine, at a dinner given at the Waldorf-Astoria on the occasion of the Academy's centennial celebration. Dr. Baehr said, "The Academy proposes to weld together the resources of the sixty-five major hospitals of this great city so as to make it the center of medical education for physicians of the Nation and of the world."

Obviously New York, because of its size, enjoys many advantages over Washington. Even as compared to cities of our own size, we are in some respects woefully deficient. Many of our hospitals, from a physical standpoint, are in a sad state. But better times are ahead for the Nation's Capital. Two three-million-dollar hospitals are now in the process of erection. A gigantic hospital center, which promises to be one of the finest of its kind in the country, has been approved by the Congress. All that is needed to get this vast project under way is authorization of necessary funds. So, while we have to admit that for the time being we are sadly deficient in hospital facilities, future prospects are excellent.

There is another and a much brighter side to the medical picture in the Nation's Capital which will do much to make it a great medical center. Government research institutions such as the National Cancer Institute, the National Institute of Health, the Army Institute of Pathology, the Naval Research Laboratories, the Bureau of Mines, and the Children's Bureau are recognized as the outstanding institutions of their kind in the world. Among the nationally known teaching hospitals are the Walter Reed General

Hospital, the Naval Medical Center, St. Elizabeths and Gallinger hospitals.

Our medical schools, George Washington and Georgetown University Schools of Medicine, are rapidly coming to the fore. Changes have recently been made which will strengthen the teaching staffs immeasurably. Both of the schools will soon have fine hospitals as teaching institutions.

Your Observer would like to mention one other development which, in his opinion, holds great promise and which will have much to do with Washington taking its proper place in the medical world, that is, the influx since the War of many able, young physicians. Nearly all have been trained in the finest medical schools, the majority having several years of postgraduate training. Upon this group, and there are some 200 or more of them who have become members of the Medical Society in the past year, will rest responsibility for medical leadership in the near future. Your Observer has not only been impressed by their qualifications, but by their keenness and determination to make Washington widely known for the best in medical service.

There seems to be no doubt that great things are in store for the Nation's Capital from a medical standpoint. As one of the District's outstanding physicians said to your Observer at a dinner recently, "As the world turns to Washington for guidance in political, economic and social matters, so it looks to it for leadership in health. It is therefore logical that Washington will develop into a great medical center."

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Too Many Voices Heard As most physicians are now aware, the American Medical Association has a representative in Washington whose task it is to keep himself and the Association informed with respect to health legislation introduced in the Congress. What is not so generally known is that there are three other medical organizations represented in the Nation's Capital. One has no regularly employed representative, but its officials visit Washington frequently. Organizations and those who represent them are: the American Medical Association, Dr. Joseph S. Lawrence; the United Public Health League, Mr. James J. Boyle; and the National Physicians Committee, Mr. Arthur L. Conrad. The American Association of Physicians and Surgeons relies upon its officers and their source of information for guidance in legislative matters.

Your Observer is well acquainted with two of these representatives, Dr. Lawrence and Mr. Boyle. He knows them to be capable, conscientious, and friendly men, who work in harmony and have a high regard for each other. Mr. Boyle is satisfied that Dr. Lawrence should take the lead and where indicated speak for the medical profession. In addition, he keeps the medical societies in the Western States, which he represents, informed of what is going on in Washington. There is no conflict here, only good will and coöperation.

No such relationship exists between the AMA representative and those of the two other organizations. Not that there is unfriendliness, but there is no close working arrangement. In fact, both the NPC and the AAPS have their own special way of appealing for support, and they are particularly anxious that they shall receive all the credit due them. Otherwise, of course, there would be no justification for their existence. In view of these circumstances, it is not surprising that law-makers wonder at times who really speaks for the medical profession.

Now most doctors are far removed from the Nation's Capital. If they are at all interested in the efforts being made by these various groups to combat "socialized medicine," they accept reports given them at face value. Your Observer does not suggest that any of these organizations deliberately mislead physicians. It is natural for each of them to wish to appear in the best light possible before the group it claims to serve. But the facts, in your Observer's opinion, do not justify the continued support of all of these organizations which are obviously not needed.

In what he has to say about the activities of the NPC and AAPS in particular, your Observer wishes it understood that no personalities are involved. He has very slight acquaintance with representatives of these groups. However, on the basis of considerable experience in Washington, he feels strongly that their services can be dispensed with to the benefit of the medical profession generally.

The spotlight might first be turned on NPC, which is financially and otherwise the stronger of the two and which has the blessing of the AMA's House of Delegates, although some state medical societies have not given their endorsement. Incidentally, the Medical Society of the District of Columbia is one of this group. NPC has been primarily a propaganda organization. It has distributed a vast amount of printed material. Some of it, in your Observer's opinion, has been of questionable taste and accuracy. He also questions the support it has won for the medical profession among thinking people. In agreement with this view have been a number of individuals of standing with whom he has talked, including an official of the United States Chamber of Commerce, who requested him to comment on some of the pamphlets which had been received by the Chamber. This official was quite disturbed by the statements contained in them, which he termed exaggerations and not conducive to making friends.

However, as is well known, NPC does not confine itself entirely to issuing bulletins, pamphlets, and so on, but has in its employ able professional public relations counsel. They are very often in Washington, the one most frequently seen being Mr. Conrad. He makes independent contacts, and apparently discusses the medical situation with the various Senators and Congressmen. He also arranges for the appearance of officials of NPC before Congressional committees.

Last year, Dr. E. H. Cary, President of NPC, appeared before the Senate Subcommittee on Education and Labor, when it held hearings on the Wagner-Murray-Dingell bill. Representatives of the other groups also were heard during the hearings, which patently had very little significance except as a sounding board for proponents of compulsory sickness insurance. After the first few sessions it was obvious that there was no cause for alarm and that the passage of the Wagner-Murray-Dingell bill was not even a remote possibility. It can be said, therefore, that no one of the groups represented defeated the bill It was doomed from the beginning. People were fed up on Government regimentation, and the representatives in Congress were fully cognizant of this fact.

Neither NPC nor AAPS have been averse to claiming credit for defeat of this legislation. Both state that the AMA is not in a position to participate in "politics." Both say they are on the friendliest terms with the AMA. That is obviously true of NPC, and that is the reason for its existence. The President of AAPS, in his annual address, made his organization's friendship for the AMA a matter of record when he said, "Let me assure you AAPS was not organized, nor has it operated to compete with the AMA or any other ethical group. It was organized to assist the AMA in the work of representing physicians." On the other hand, the same speaker says of the Association's critics, of which Dr. Morris Fishbein, Editor of the JAMA, is one, that "it requires a child's fantastic imagination to reconcile their ridiculous utterances with the facts." Directing his attention to Dr. Fishbein, who is openly critical of AAPS, the President said that the AAPS was so organized "that it became the first truly representative national medical association."

What has prompted your Observer's comments more than anything else is a wire received by the Secretary of the Medical Society of the

District of Columbia from AAPS's new President, Dr. William P. Howard. He urged opposition to S. 140, the so-called Fulbright-Taft bill, providing for the establishment of an executive department of the Government to be known as the Department of Health, Education and Security. The Association suggested that representatives of the Society appear at committee hearings on this bill, stating that only "combined protests of the important state societies, county societies and thousands of individual physicians" could bring about its defeat.

This was too much for your Observer. In the first place, any such procedure as proposed by AAPS might very conceivably have an adverse effect in so far as medicine is concerned. As every person experienced in legislative work knows, damage is often done because too many purport to represent the views of their groups. If representatives of every medical society aired their opinions before a Congressional committee, hopeless confusion would result.

The truth of the matter is there are too many spokesmen for the medical profession in Washington. There are also too many organizations "bulletining" physicians—or rather, briefing physicians on what they should do to stop the inroads of "socialized medicine." It is high time that doctors in this country realize that the American Medical Association is most adequately represented in the Nation's Capital by Dr. Lawrence; that the AMA also has an excellent department handling legal and legislative matters in Chicago, of which Mr. J. W. Holloway is the able head. This department works hand in hand with the Washington office. Other medical organizations with the same point of view, if their supporters believe them to be essential, should rely upon the AMA's leadership in legislative matters, allowing it to "carry the ball." To do otherwise is just not good sense, and may jeopardize organized medicine's position.

Old People The present age trend in our population has led experts to predict that by 1980 two-fifths of our people will be over 45, and one-seventh over 65. On the basis of the expected over-all increase in population, it is estimated that there will be at that time about 150 million people in this country, which would mean that there will be not less than 60 million 45 years and over, and more than 21 million 65 years and over. The significance of these figures is all too plain. Physicians, economists, sociologists, and public officials will in the coming years be faced with the most serious problems in the country's history.

Important as usefulness, contentment, and comfort are to the aged, none of these is possible without reasonably good health. In the light of our present knowledge of degenerative diseases, this presents many difficulties.

> "Our research," says Dr. Theodore G. Klumpp, President of the Winthrop Chemical Company, "has not scratched the surface of such problems as heart disease and coronary thrombosis, nephritis, arthritis and cancer. We know more about the planet Mars than we know about the pathogenesis of arteriosclerosis, which is probably the least common denominator of most of the disabilities of the aging process."

Of course, Dr. Klumpp does not mean to imply that progress has not been made in the control of degenerative diseases. He says, what all physicians know, that we still have a great deal to learn about the cause and the cure of diseases which commonly afflict the aged. However, research in this field is rapidly expanding, vast sums having recently been made available for this purpose.

But not all old people are ailing, nor are all people of advanced years old in a biological sense. To so regard an older person who is vigorous and mentally alert is nothing short of cruelty. There is no reason why the aged who are in good physical and mental condition should not continue to be useful. In fact, they may very well be more useful than those many years their junior. Naturally, they cannot understand the attitude which is often taken toward them. Dr. Klumpp states their case very well when he says:

> "What to do about the aged and the partially disabled? We can't plow them under as we used to plow under corn, potatoes, tobacco, and little pigs. And I am equally certain that we can't just turn them out to pasture and expect them to enjoy life. People are not happy when they are idle and this is particularly true of older individuals. Youth can loaf content with opiate dreams of future achievements. But as we grow older the realities of life are more clearly seen and less easily denied and as we approach 50 and 60 we can no longer derive solace from the pipe dreams of future achievements. Similarly the diversion of participation in sport and exercise is denied us. Age plays for real stakes not pastime. It wants something to do and it must be real. And the most real thing we have to sustain us in this life of ours is useful work for which we are paid in money or its kind. Have you seen, as I have, a faithful employee who has been working at his job for 20, 30, or 40 years and wants to continue? Have you seen such an employee 'retired' to the boneyard by some blind compulsory retirement scheme? There is an unutterable sadness about it that sometimes makes me think that it would be kinder to shoot the old fellow. I believe I understand why so often they die shortly after retirement."

All of which leads to the observation that insurance companies have perhaps unwittingly contributed to the prevalent attitude when they portray the retired individual of 50 or 60 with ample funds as a picture of contentment. Not long ago your Observer was called upon by a well-known insurance man in Washington who, during the conversation, mentioned a local physician in his thirties. This physician, the insurance man said, had made provisions for his retirement at 50, and he was building a "large estate," meaning that he had purchased a more than adequate retirement insurance policy.

This physician, in your Observer's opinion, is living in a fool's paradise. For he has seen enough of retired individuals to know that money to satisfy all one's wants is not sufficient. There must be some purpose in living, and that purpose must be a useful one. It would be far better for this physician to make such modest financial provisions for his old age—and that would not mean 50 or 65 for that matter—that he and his family could have the minimum necessities of life. If he wished for luxuries, he would have to earn them or do without.

Insurance companies may not like such statements as these, but in your Observer's opinion, they are only too true. Examples of complete frustration where there is no incentive or need to work are too commonplace to refute.

As to compulsory retirement at 65, your Observer is in entire agreement with Dr. Klumpp. It is not only unreasonable but stupid to specify a definite age for retirement.

> "We may not fully realize it," says Dr. Klumpp, "but we cannot afford to waste the contributions of those who through years of experience have learned to do their jobs well and are willing and able to continue to do so faithfully. Training and experience can only be replaced by training and experience and when we retire a competent older worker his successor has the burden, inevitably, of supporting him as well as himself. Some individuals welcome retirement and the possibility of voluntary retirement on a pension should always remain open for these. But, if the premise is that all individuals over 65 or 70 are not worth their keep then least of all should we permit individuals above those ages to occupy the top and critical positions in our social structure."

Now what significance does this have for physicians? A great deal. For your Observer is probably more keenly aware of the problems of aged doctors than most physicians, especially the younger ones. He has often been made sad by the plight of some doctors who, through no fault of their own, have fallen upon hard times because they have lived beyond the years when they can earn a living. Certainly they should have taken steps when they were younger to provide for the necessities of life in their closing years. He has also witnessed the unhappiness of middle-aged physicians who have retired in anticipation of a life of ease. The disillusionment which ensued was devastating and contributed more than anything else to early mental and physical deterioration.

Specialty Bo rds Criticized

Only in recent years have physicians felt it necessary to qualify themselves for specialties by extensive postgraduate training and by taking examinations given by specialty boards. All that was required a decade or so ago was for a physician to have graduated from a recognized medical school, to have taken his internship, and to have obtained his license to practice. Thereafter he could, within certain limits, practice whatever specialty he liked.

Of course, there were many physicians who frowned upon such practice, and who had prepared themselves thoroughly for the specialty in which they engaged. But a considerable number did not bother to do so, relying upon a preceptorship arrangement with an established specialist for their training. In fairness it must be said that some of these physicians reached high eminence, and from any point of view were successful. However, not a few of the unqualified did a great disservice to their colleagues, reflecting discreditably on the profession generally. A more scientific approach was needed, and the specialty boards came into being.

One of the problems which confronted the boards in the early days of their existence was what to do about specialists already established. It was finally decided that they should be taken in on the basis of their experience and accomplishments without examination. Many well established physicians, however, felt no need of a specialty board endorsement. Others, for reasons not made public, were not acceptable to boards, even though they had extensive experience. Bitterness inevitably resulted and charges of favoritism were soon heard and became a source of much irritation.

Some physicians have expressed the view that specialty boards are too exclusive, and that their standards are unreasonable. But the fact is that some means had to be found to assure the public that those who practice in a specialty are capable of doing so. And whatever one may think of these boards, one cannot quarrel with their objectives. It now seems certain that though the organization structure of these boards will undoubtedly change, it is only a matter of time when no physician will engage in a specialty unless he has passed his board.

As your Observer has intimated, not all is sweetness and light among physicians where specialty boards are concerned. There are still critics who look askance at them. One of these is Dr. Norman C. Ochsenhirt, Secretary of the Allegheny County (Pittsburgh, Pa.) Medical Society. While he agrees that the objectives of these boards are praiseworthy, he says that hospitals have "gone overboard" in their demands for specialty board certification. Writing in the *Pittsburgh Medical Bulletin* for March 1, 1947, Dr. Ochsenhirt says:

> "In many hospitals physicians, who have shown by their clinical ability and results over a period of years that they are competent in their chosen field of medicine, have been replaced by younger physicians with board certification. Frequently the younger man has had no clinical experience other than that obtained during hospital residency required by the board. These young men, too often, have had no experience in the art of medicine. We are too prone to lose sight of the fact that there is more to the practice of medicine than scientific training. No one is better equipped to judge an older physician's qualifications for hospital appointment in a special field of medicine than his staff colleagues, who know intimately his clinical experience, ability and training.
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> "In some specialties much confusion exists regarding certification. For instance, in surgery there exist two organizations—the American College of Surgeons, which has functioned for so many years, and the American Board of Surgery, a creation of recent years. The American College of Surgeons has always recognized the importance of clinical experience and scientific training as a prerequisite for membership. Recently approximately 100 diplomates of the American Board of Surgery were refused admission to the American College of Surgeons because of insufficient clinical experience. In spite of such action, some hospitals and governmental agencies have at times questioned the ability or qualifications of a Fellow of the American College of Surgeons who is not a diplomate of the American Board of Surgery; such disunity in the field of surgery—and it exists in other fields of medicine—can lead to only one result—either the failure

of medicine as it exists today or the complete destruction of our present method of practice. Such differences must be removed and a fundamentally sane, common basis established for specialty certification.

"... Many boards have been created for specialties of a very limited field and unless the general process is soon controlled by the medical profession it may lead to even narrower or more ridiculous lines of demarcation in specialization.

"... In many instances they are unreasonable. A proctologist must pass the American Board of Surgery examination before permission is granted to take the Proctologic Board examination with subsequent certification as a proctologist if successful. The result is that in this country there are approximately 100 or less certified proctologists, over 75 per cent of whom were certified in the founders' group without examination. Why not insist that orthopedic surgeons, gynecologists, urologists, neurosurgeons, etc., pass the American Board of Surgery examination before permission is granted to take their specific examination?

"With the creation of the specialty boards, there has been a wild scramble for hospital residencies to qualify for board examinations. Residencies for an adequate period are necessary in the preparation of a physician for any specialty. At the close of World War II, the number of residencies was greatly increased beyond reason because of the increased demand by the returned veterans for qualifications for board examinations. Too often no consideration is given as to the qualifications or aptitude of the young physician for his chosen specialty. Very few physicians actually find themselves, without several years of general practice. Then and then only do they learn for what specialty—if any—they are best suited.

"With our present system created by the boards we shall see many specialty misfits, regardless of the length of training as a hospital resident—whether it be 5 years or 10 years."

Undoubtedly, there is much truth in what Dr. Ochsenhirt has to say, but the fact remains that specialty boards have raised the standards in medical specialties. Some tinkering with their machinery is needed, but that does not justify discarding the whole set-up. There are, and will be, conflicts until the younger generation of physicians takes over. Furthermore, there will also be misfits regardless of how specialists are qualified. As to the latter, it seems certain that they will be much fewer in number than "in the good old days."

Times Have Changed But — —

When physicians are particularly wroth about injustices to their profession, they talk about forming a union. However, such statements should not be taken too seriously. The vast majority of physicians in this country are not receptive to the unionization idea. Those who feel otherwise are not numerous enough to count. Views of the editor of *Philadelphia Medicine* on this subject, your Observer believes, reflect the opinions of the majority. He writes in the February 22, 1947, issue of that publication:

> "Physicians have felt that their calling was somewhat akin to that of the clergy, the latter being concerned chiefly with things spiritual and we with things of the flesh and mind. Our duty, as we have seen it, is always to the individual, to alleviate his sufferings, to get him well, if possible, in the quickest possible time and always without regard to our own convenience or most desirable hours to work."

Reference is then made by the editor to the report from England that physicians and nurses of two London hospitals were dismissed because they refused to comply with an order of the Willesden Borough Council to affiliate themselves with a trade union. According to a United Press dispatch, the Willesden Maternity Hospital found itself in a situation where only one doctor, the medical superintendent, was left to care for 100 patients. Commenting on this situation and the growth of the union movement in this country, he observes that the recent strike of school teachers indicates a trend, and suggests that what has happened in England may very well happen here.

Your Observer cannot conceive of such a shift in opinion among the medical profession of the United States. Although doctors have had their legitimate grievances, resorting to trade unionism certainly would not be the solution. If public ire were raised to a high pitch because of the coal strike and its effect upon the public welfare, how much greater would be the resentment if similar steps were taken by a doctors' union, regardless of the justice of their cause.

Doctors would fall so rapidly in public estimation that years would be required to regain public confidence. Such a move is, therefore, not conceivable, nor in your Observer's opinion even possible. Physicians have too high a regard for their calling to jeopardize it by such tactics.

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Training Tomorrow's General Physician

Pointing out that as medicine "becomes more and more precise and scientific, specialization is inevitable," Dr. Lester J. Evans, Medical Associate of the Commonwealth Fund of New York, observes, "Specialization in turn adds to the fragmentation and segmentation of medicine. For the patient, whether well or sick, this means added difficulty in obtaining comprehensive medical care, when defined in terms of continuity, quality, and completeness of service. No short cut to the integration of specialized knowledge and skills into comprehensive medical care has yet been devised, but until this problem is solved, medicine—and the training for medicine—will be inadequate."

"Our present educational system, especially in the graduate years," Dr. Evans continues, "is geared primarily to the training of specialists and not to the integration of medicine. Even in the undergraduate years, the student sees medicine from a series of limited points of view. To become a specialist has seemed the desirable goal. Those students who do not become specialists by following a prescribed course of training to fit them for a specific task become general practitioners. They can be defined only negatively as non-specialists. They are the product of a hit-and-miss program of intern and resident training which has taken them into various fields, one after another, for a few months or more. Their teachers, in these fields, have been oriented to the specialist's point of view. By force of circumstance, or to hold patients, general practitioners so trained often cover a wide range of activities, many superficially and without adequate preparation. They are often looked on as subservient to the specialists—mere way-stations on the patient's road to competent care. This has come about because we have worked from the periphery of medicine—the specialties—toward the center, the patient and his physician and the relation between them—instead of beginning at the center."

Dr. Evans argues that the solution to this problem lies in the training of "expert general physicians" to do the job not covered by the present specialties. One of the most important elements in this type of practice, he says, is the continuity of contact between patient and physician. If this is to be maintained, the physician must demonstrate special knowledge and skills, especially in preventive, or what is called constructive, medicine. He cites the pediatrician and the internist as the best examples of a general physician "trained for continuing care of the patient." The general physician who is properly trained should, in his opinion, take the lead in "planning for the health of the patient."

Dr. Evans outlines what he considers should be the training of such a physician in a medical school. He says that it should begin with his premedical school interest in people, and he observes:

"I should like to suggest that the well and presumably 'normal' person, in all stages of growth and development, both physical and emotional, from birth through senescence, be made the center of what might be called clinical study in the first years of medical school, just as the ill person is the center of clinical study in the last years. With a picture of the life pattern of the human organism in mind early, the student has the outlines, at least, of a framework to which he may relate, and in which he may integrate, the varied information he acquires concerning physical, physiological, and psychological phenomena of all age periods.

"An experimental approach toward establishing an initial picture of the life pattern might be made through a series of well planned consecutive exercises in the first year or two. The students, in small groups, each with an instructor, could observe, talk with, examine as their training progressed, and describe living people of all age periods, beginning with the newborn and moving through the life span. The number and timing of these exercises could be arranged to fit the curricular requirements of that period. In group discussions and in whole class sessions with all the instructors, concepts fundamental to all of medicine could be introduced and developed in terms of the students' own observations of living people.

"To illustrate, physical growth and maturation could be demonstrated simply and quickly through the changes which are seen to take place in the early years of life. The concept of the personality would have been introduced quite early when the students, in comparing their observations on young infants, noticed the differences in the response of the infants to them as strangers. Full appreciation of personality, however, would not come until the path of emotional development had been traced from infancy through childhood and adolescence into adult life. This could be done through instructor demonstrations, class lectures, and student study of a few basic emotional phenomena.

"As the student extended his knowledge of individuals, other concepts or formulations, such as the range of 'normal' variability, would come into view. Quite early in this series of exercises, the students, as they compared their group observations, would become more acutely conscious than they had been before entering medical school of the differences in people of the same age and sex. Differences in such gross things as height and weight would be obvious. Soon, such things as texture of the skin, fat distribution, and muscular development would be noted; then the response to a few simple physiological tests, and the reactions to conversation and questioning. Not only could the students thus learn to observe physical, physiological, and psychological variability but they would also come to realize that study of the normal individual can be as fascinating and challenging as study of the abnormal."

Dr. Evans' conclusions with respect to this phase of his discussion are "that the integration of medicine would be brought perceptibly nearer by the training of the good general physician, that the general physician offers the simplest road to comprehensive medical care, and that his training must rest on a sound knowledge of the human life pattern."

Finally, he says, "All will admit, however, that if the general physician is to do the job we visualize for him, his position must be given dignity commensurate with the responsibility he will carry. He will first sense that dignity from his teachers if they display the energy and ingenuity necessary for his successful instruction. It is with their help that he must acquire the knowledge and skill which his patients will recognize as essential to their well-being. The patients will respect the general physician when they see him as the doctor who, either alone or with the aid of others, helps them unravel their total problem in a way no one else does."

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Our Confidence Not Shaken

Those who do not agree with the course organized medicine has pursued in social and economic matters have resorted to many methods to win medical support for their views. Persuasion, cajolery, and even threats have been used in an attempt to bring about the desired result. It is the latter method which has been particularly offensive to your Observer.

Not long ago at one of the Medical Society's business meetings, physicians present were warned to act favorably on the matter of business before it, because the medical profession was decidedly not in good favor with the public, and, for that matter, had not been for a long time. It therefore behooved physicians to behave circumspectly.

Undoubtedly, the physician who expressed these views was sincere and would be shocked at the suggestion that he was threatening the profession with dire consequences unless it acquiesced to the proposal before it. Nevertheless, that is what it amounted to. Furthermore, it had the effect of shaking the profession's confidence in itself, and that, in your Observer's opinion, is not justified by the facts.

Of course, organized medicine has made its mistakes, and some of them the public has vigorously disapproved. As a matter of fact, there are a number of individuals within organized medicine, your Observer being one, who has not always agreed with the course organized medicine pursued, especially where needed changes in medical practice were concerned. But the truth is that despite its mistakes, it still retains public confidence. Your Observer believes this not only to be true of the national body, but also of its state and local units.

It might be well to get down to cases right here in the District of Columbia. With few exceptions the public, and that includes lay groups such as civic, business, and service organizations, relies upon the Medical Society for leadership and advice where medical matters are concerned. This is also true of the departments of the Government, national and local. Hundreds of individuals call upon the Medical Society every month for such assistance as it can give, usually advice and information with respect to physicians. Your Observer can in all honesty say there has been little evidence of distrust, or any feeling that the Society is not sincerely concerned with the health and welfare of the people, expressed by those who have talked with him.

Again, let it be understood that the public will not always agree with organized medicine, for organized medicine will not always do the popular or, for that matter, the right thing. Regardless of this, it is your Observer's belief that the majority of the people do not question the honesty of its leadership. What they have questioned is its judgment in dealing with the distribution and costs of medical care. Even on this score critics have been encouraged by indications that organized medicine is much more realistic than in the past.

Your Observer wishes, therefore, to reiterate that threats of public disfavor are not only unjustified, but give an entirely erroneous impression to the unsuspecting physician.

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How Civilized Are We?

It has seemed to your Observer that wherever he goes, there is discussion about age. The point is frequently made that so-and-so is slowing up and is not what he used to be. That is undoubtedly true of most of us, for nature has decreed that our physical processes slow down with the years. But as mentioned elsewhere in this month's column, there are ways in which we become more efficient, too. We may be less observant with advancing years, but we certainly are better able to evaluate what we see. And what the adult of mature years sees in these days does not make him particularly happy. For no one of ordinary intelligence who has reached his middle years can escape the conclusion that the people of the twentieth century are still surprisingly uncivilized.

That is not to say that our society has not greatly improved over what our forebears knew. But there is still a long road ahead. Injustices, indifference to public welfare, downright negligence, and even stupidity are so commonplace as to make us despair. Numerous examples of what your Observer has in mind are to be found here in Washington. It should be said, however, that they are not peculiar to the Nation's Capital, for they exist in every part of our country.

A good place to begin is with the alcoholics. Could anything be more uncivilized than the treatment given most of these unfortunate individuals? We accept the fact that alcoholism is a disease, but still continue to send victims to prison as ordinary criminals. It is true that forward-looking jurists, leaders in the social welfare field, physicians, and the Alcoholics Anonymous are all doing much to rectify injustices and to salvage the lives of alcoholics. But the situation is still very bad, and reflects upon the state of our civilization.

Equally shameful is our manner of dealing with sex perverts. How often one reads that an individual has been incarcerated for such an offense, only to repeat it upon his release. And too frequently this individual goes berserk and murders some innocent person. There is something wrong with a civilization that permits these people to prey upon the innocent and unsuspecting public. They, too, are diseased and should be confined to institutions provided for their care. Sending them to prison solves nothing.

Then there are the emotionally unstable who can be counted in the hundreds of thousands, probably in the millions. It is undoubtedly true that they are a product of our times. But by preventive treatment an enlightened civilization should feel itself obligated to take immediate measures to prevent further inroads of mental disease. Some progress has been made in this direction, mental hygiene clinics having been established in various cities, but they merely scratch the surface of the problem. Even if one admits that psychiatry is still in its infancy, it has at its command sufficient knowledge to cope with the milder forms of emotional disturbances on a much more ambitious scale than at present, thereby averting tragedies which often ensue.

The treatment of aged persons is one which reflects no credit upon civilized society. Considering the growing number of aging people, it is inexcusable that we do not now plan more adequately for their care.

These are just a few of the ways in which we reveal the uncivilized state of our society. The medical profession cannot escape its responsibilities in this matter. Its voice will be listened to with respect and it should make itself heard.

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Nazi Doctors Stand Condemned

It will remain a mystery to the medical profession in this country how "distinguished" German physicians, despite their adherence to Nazi racial doctrine, could so debase themselves as to engage in the wanton brutality described at the Nürnberg trials. One is not surprised that the Nazis have tried by every means possible to hide their horrible crimes. However, as these lines are written, their degradation is being exposed in a trial of twenty doctors and scientists and three laymen.

It has been shown that the physicians being tried have performed unspeakable experiments on what the "master race" chose to call "inferior peoples." According to Dana Adams Schmidt, Special Correspondent for the *New York Times*, they constituted "a program of extermination by gassing, lethal injection and sterilization conducted in remote clinics, asylums and concentration camps." Described by witnesses were experiments to determine the effects of high altitude and freezing, poisoning induced by bullets, wood shavings or ground glass rubbed into wounds, spotted fever, bone and muscle transplanting, use of sulfanilamides, and bombs.

Dr. Gerhardt Rome, said to be the most "distinguished" defendant, having gained an "international reputation" in his field, tropical medicine, is charged with having provided fly eggs for malaria experiments at Dachau, which resulted in 300 or more deaths. But this experiment was mild compared with many others.

There seems to be no plausible explanation for such savage behavior, unless it lies in the character of the German people. However, such a conclusion would be unjust to German physicians. There were undoubtedly many of them who, if they knew what was going on, were as shocked as their colleagues in other countries. Whatever the explanation, physicians everywhere will feel a deep sense of revulsion against medical men who perpetrated the outrages at Dachau and other concentration camps.

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Footnotes

Paul W. Griffith, National Commander of the American Legion, told the press a few weeks ago that the Veterans Administration's hospital construction program will soon get under way. General Omar Bradley, Veterans Administrator, has informed Mr. Griffith that he (Bradley) had received the "go" signal. Of the 72 hospitals proposed, Bradley is quoted as saying, 63 are definitely authorized, and construction will start on them within the very near future. Much remains to be done, however, before actual building begins. Preparing architectural plans alone requires as much as ten months for a

1000-bed hospital. There is also the matter of selecting sites. Nevertheless, the VA program is getting up steam, which is, in Mr. Griffith's mind, the important thing. * * * The United States Public Health Service is conducting a study of medical group practice in the United States. The study is under the direction of Dr. G. Halsey Hunt, Senior Surgeon of the Service. Early in the summer of 1946 questionnaires were mailed to all groups appearing on lists of the American Medical Association, Medical Administration Service, Inc., and the National Association of Clinic Managers. Returns, it is reported, have been satisfactory and a statistical summary of findings will soon be published. A directory of the groups from whom information was obtained has just been issued under the title, "Medical Groups in the United States, 1946." Because there has been no accepted definition of what constitutes a group, Dr. Hunt points out that the directory has been made as inclusive as possible. The only qualifications required are "first, that it [the group] have some sort of formal organization, and second, that it have at least three full-time physician members." Dr. Hunt states that he will welcome any comments which physicians or others may have to make with respect to the directory. * * * Due to the coal crisis, the *British Medical Journal* for February 22, 1947, consisted of a single, mimeographed sheet. Commented the editor, "This, the smallest B.M.J. since 1840, has been 'printed' on hand-operated duplicators in B.M.A. House, by permission of the Ministry of Fuel and Power and the C.O.I. Our 'printer' this week is the Secretary of the B.M.A." * * * A recent innovation at Johns Hopkins Hospital received nationwide publicity. Operations were televised to physicians in various parts of the hospital in an effort to determine the practicability and the value of television in surgical teaching. The experiment, it appears, was successful. One of the physicians, Dr. Edwin L. Crosby, Director of the Hospital, said according to the press, "The physical limitations of amphitheaters sharply restrict the view of the operating field. Television brought the operative field within the critical sight of large numbers of doctors and students and permits them to witness many operations." * * * In Spain the national health insurance scheme has been broadened to include agricultural workers and all who cannot pay for medical care on any other basis. At the first national convention of the government, trade unions, and health insurance organizations, held late in February, Fermin Sanz Orrio, representing the unions, declared that though a similar scheme had failed in supposedly more advanced countries, in Spain it was succeeding. * * * When a Gypsie "Queen," Mary George, of the Gypsies, died in Philadelphia recently, Dr. Joseph O. Keezel, who performed the operation upon her eminence, was in a tight spot. According to press reports, Gypsies battled hospital attendants in an unsuccessful effort to reach the surgeon, but were finally routed by several details of policemen. Dr. Keezel said that he tried to dissuade the "Queen" from having the operation, but that she had insisted upon it. The "King" did not depart until he reportedly tore a shade from a window and tried to leap out. * * * An author of a much publicized scientific article which appeared in the MEDICAL ANNALS a few months ago has received communications from all parts of the country. One of those began: "I've 'split' the living cell; it functions in the next state-dimension; it evolves in the eternal now from plane-level to plane-level regardless of the disintegration of the 3rd state-body." That is something for the doctors to ponder. * * * No one in Washington, it seems, escapes "red tape," even "poor little mice." It appears that a newspaper reporter called upon Dr. Egon Lorenz of the National Cancer Institute, in charge of mice which had been subjected to bombardment by atomic irradiation at Bikini last year. He was told by Dr. Lorenz that he couldn't say

(*Continued on page 229*)

The Editors' Forum

RICE WITHOUT GRAVY

Julian P. Price, M.D.

Editor, The Journal of the South Carolina Medical Association

Editor's Note: As readers of this article will discover, Dr. Price has a sense of humor and a discerning mind. He is also one of the ablest and best liked of all state medical editors and secretaries. Editors and program committees can always count on original, worthwhile contributions from him. Impatient with "conservatives," he is forward-looking and progressive with a practical turn of mind.

One of the basic foods in many Southern homes is rice, and it is considered, along with biscuits, the sine qua non of a good dinner. Each cook is proud of being able to prepare it so that every kernel stands by itself, and considers her efforts as vain if the food presents a soggy, wet appearance.

But regardless of how well the rice has been prepared, no hostess would consider serving it to her guests without good gravy. Rice may be the basic food, the substance which satisfies the hunger and fills the inner void, but it is the gravy which tickles the taste buds and renders the dish savory and appetizing. Of course it might be possible to eat rice without gravy, reasons the Southern lady, but it will not be enjoyed and there would be no requests for a second helping.

As I have read articles and editorials in medical journals, as I have heard papers presented at medical gatherings, as I have listened to addresses delivered by physicians before professional and nonprofessional audiences, I have often wondered whether the writer or speaker might not be making the mistake which the Southern lady refuses to make, that of serving rice without gravy.

The average physician, as I have seen him, is a good conversationalist. Watch him as he sits with a group of his colleagues. He knows humorous stories and he tells them well. Quick at repartee, he exchanges sallies with this person and that. During a general discussion, his facial movements, his spontaneous gestures, his unusual method of expressing himself, his use of certain words and phrases which are peculiarly his own, blend to give sparkle and individuality to the ideas which he presents and the arguments which he advances.

Now drop the curtain and let it rise upon another scene—the average physician as he prepares a paper or address for public presentation. Brushing aside those very things which make him a good conversationalist, he draws within the shell of austere traditionalism and fills his manuscript with time-worn expressions, trite phrases, hackneyed similes, soporific sentences, and ponderous pronouncements. Beset by the belief that all medical writing must follow a set pattern which has come down through the years, he resists all temptations to allow his own individuality the opportunity to express itself. And the result—a work which could be accredited to a hundred authors without a reader or listener being the wiser, a presentation which might appease the hunger of the few but which will fail to titillate the appetites of the many to whom the message is given.

Perhaps it would not be amiss for those of us who are average physicians and who are afforded the opportunity to write and to speak, to observe well the Southern lady as she prepares her dinner for her guests. She spares no pains to see that her rice is well cooked, but she also prepares her gravy with equal care. Under no circumstances would she insult her guests by serving rice without gravy.

STATEMENT IN OPPOSITION TO THE LEMKE BILL: H.R. 462*

I am grateful to the Chairman and the Committee for this opportunity to present the other side of this question. Since the retirement of Dr. George McCoy in 1938, as director of the United States Public Health Service, I have succeeded to his role of chairman for those wishing to appear as witnesses in opposition to this bill.

My name is Frederick Coleman Fishback. I am a graduate of the Harvard Medical School (1922). I am a member of the Medical Society of the District of Columbia, of the American Medical Association, a Fellow of the American College of Surgeons, a member of the founder's group of the American Board of Surgery, and Professor of Clinical Surgery at the Georgetown University School of Medicine. I am here today at the invitation of Congressman Miller as a representative of the Medical Society of the District of Columbia.

The first anti-vivisection bill was introduced in Congress in 1896, and during the intervening years, similar bills have been introduced from time to time. On frequent occasions there have been public hearings, some lasting several days. The most recent hearing was held on February 28 and March 1, 1946, before the Judiciary Subcommittee of the House District Committee. I have placed in your hands copies of the transcript on the last hearing on this bill, and would call your attention to that portion from pages 20 to 43, inclusive. What I shall say will review briefly the statements of eminent witnesses from medical schools, the Public Health Service, the Medical Corps of the Army and Navy, the Bureau of Animal Industry, our local Health Department, and the Medical Society of the District of Columbia.

This bill, like its predecessors, asks you to assume two things, first, that dogs are treated with unnecessary cruelty, and second, that no good has ever come of experiments performed on anesthetized animals or dogs. My remarks shall be confined to these two points.

Some of you gentlemen have visited the animal laboratories of the George Washington University School of Medicine and the Georgetown University School of Medicine. I believe you have been given copies of the rules and regulations governing the care and treatment of animals. I have here the regulations in force at the National Institute of Health. These rules are uniform in the laboratories where experimental animals are used in this country.

During two years of my graduate training, I was first assistant in experimental medicine at the Mayo Foundation, and during that time I saw many dogs operated on, but in no instance without the benefit of complete general anesthesia. The care of dogs before, during, and after operation was as good and considerate as that enjoyed by humans in hospitals. Even in the 20's dogs received intravenous feeding and endotracheal or intravenous anesthesia, items which are now used generally on humans to enhance their comfort and safety while undergoing serious operations. It was through the perfection of these methods on dogs that such measures are now taken for granted as routine procedures on humans.

In 1937, Dr. George McCoy made a careful survey and found that 429 dogs had been used for experimental purposes in the District of Columbia. A similar survey conducted in 1945 revealed that 407 dogs had been so employed. A tabulation of the ten-year-period, just past, which your Committee requested, showed that an average of 476 dogs were used annually by the medical schools, Food and Drug Administration, the Public Health Service and the Army and Navy.

There is ample provision under the present law to punish cruelty to any animal. The District Code (1940, Section 22, -801, 802, and Section 11, -603) provides penalties for "unnecessary" cruelty to animals. Such cruelty does not have to be either wanton or willful.

Now in answer to the assumption that no good has come from experimental work done on animals, let me recount briefly some of the more important recent examples.

Benefits to Dogs and Other Animals

Dogs have themselves been greatly benefited by their use as experimental animals. It may surprise many proponents of this bill to learn that dogs were used primarily in certain experiments to find a cure for a particular disease in dogs. In 1921, the Bureau of Animal Industry, searching for an effective treatment of hookworm in dogs, found that carbon tetrachloride was a safe remedy. Subsequently, the same drug was found to be equally effective in man. Its discoverer, the late Dr. Maurice Hall, tried the drug on himself. He later found that another drug, a closely related compound, tetrachlorethylene, was slightly safer and quite as efficient.

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* Presented by Dr. Frederick C. Fishback, Chairman of the Medical Society's Committee on Public Policy, before the Subcommittee on Education, Health and Recreation of the House District Committee, March 19, 1947.

In 1934 a remedy was discovered for the "cruel heartworm" of dogs (Dirofilaria immitis), a disease infesting and disabling an untold number of fine dogs each year. The remedy is known as fouadin, an antimony compound, which is effective in 84 per cent of the cases of infestation. For the last two decades, small doses of carbon tetrachloride (1.00 c.c.) have been effective in eradicating the liver fluke disease of sheep. Another serious parasitic malady infesting sheep, cattle and goats is verminous gastroenteritis, and this responds to tetrachlorethylene.

Advances in Medicine

The discovery of insulin by Banting, Best and McLead (1922) and the discovery of the cure of pernicious anemia by Whipple and Minot (1925) were both based on the use of dogs as experimental animals. The totally depancreatized dog served as an index of the effectiveness of insulin while it was still in the experimental stage. In the case of pernicious anemia, dogs made deliberately anemic served as reliable test-tubes in determining what substance was most effective in promoting regeneration of the blood; as we all know, liver was found to be most effective, in sharp contrast to the current common belief that red meat and meat extracts were blood builders.

Advances in Military Medicine

At the last hearing, statements were included in the record from Admiral Ross T. McIntire and General Norman T. Kirk, summarizing the benefits of animal experiments to the well-being of the armed forces. They laid particular stress on the advances in the treatment of shock with plasma and whole blood, the treatment of burns, and the determination of adequate dosages of the sulfonamides and antibiotics (penicillin and now streptomycin) to combat infection resulting from battle wounds. The vaccines and biologics used to protect our men from manifold diseases resulted from prolonged experimental researches.

The discovery of remedies, again antimony compounds, for filariasis and schistosomiasis was a product of experiments in which dogs were used. Since these dogs living in the South Pacific harbored a similar parasite, they were considered suitable and sufficiently important to be flown from Guam and Leyte to Washington for experimental purposes. There was a real need for an effective remedy for these tropical diseases to combat their potential spread in the Continental United States by troops infested in the South Pacific.

Through the use of animals, the Chemical Warfare Service determined the toxicity of various gases and the best means of combating them. Since the advent of the atom bomb, animals have been extensively used to solve many of the problems of radioactivity.

Advances in Surgery

There have been great advances in surgical technic. Among the many refinements was the development of fibrin film and fibrin foam for the control of oozing and hemorrhage. Aseptic types of intestinal anastomosis have been worked out on dogs, making removal of large portions of the stomach and bowel quite safe. Methods of excising the esophagus for cancer or stricture were evolved on dogs. Prior to 1937, there was only one cure of cancer of the esophagus, and this patient lived with a rubber tube connecting the proximal esophagus in his neck with an opening to his stomach in his belly.

Cancer of the lung constitutes about 10 per cent of all cancers. By the use of dogs, safe methods for removing a whole lung or a lobe of the lung were devised. This is particularly true in effecting a secure and dependable method for closing the end of the bronchus or windpipe to the portion of lung removed.

The role of the kidneys in the production of high blood pressure was demonstrated on dogs. And the surgical treatment of hypertension rests on experimental work done on animals.

Our knowledge of duodenal and gastric ulcers is based largely on experimental work done on dogs. How extensive a portion of the stomach should be removed to cure peptic ulcer was determined on dogs. Recent work, done within the last four years, seems to indicate that cutting the vagus nerves will cause ulcers to heal by diminishing gastric secretion and motility as a result of eliminating psychic stimuli from the brain.

Several operations have been devised for increasing the blood supply to the poorly nourished heart muscle in patients suffering from an inadequate coronary circulation. This work is based solely on experiments performed on anesthetized dogs. In fact, the whole field of cardiac surgery is founded on a solid foundation of experimental investigation. The suturing of wounds of the heart has been placed in the category of routine surgery, as a result of the use of appropriate experiments to develop a safe and sure technic.

During the past War, one young American army surgeon reported 134 operations for the removal of foreign bodies from the pericardium and chambers of the heart, without a single death. I am sure that a single showing of his movie would satisfy anyone of the value of experimental surgery.

Before closing I want to mention three contributions to surgery of the heart and great blood vessels. The brilliant work of our Baltimore neighbor, Dr. Alfred Blalock, was demonstrated at the last hearing on this bill. His operation relieves an otherwise hopeless condition. These blue babies are doomed to a helpless, breathless childhood and death in their teens, if they live that long. This condition bears the name of the congenital tetralogy of Fallot, and the chief symptoms are cyanosis, shortness of breath, weakness and later mental deterioration. These symptoms are the result of inadequate oxygenation of the blood, caused by a congenital narrowing of the pulmonary artery where it leaves the right side of the heart to carry blood to the lungs for the express purpose of absorbing oxygen. His operation provides sufficient oxygen by ingeniously short-circuiting one of the large systemic arteries to the head or arm to the pulmonary artery beyond the point of narrowing. This work was based exclusively on experimental work on anesthetized dogs. Only dogs could be used since smaller animals did not provide vessels sufficiently large for satisfactory anastomosis. Perhaps even more important, he warned brother surgeons that this procedure should not be attempted, no matter how dextrous the operator, without practice on more than one dog. Dr. Blalock has now operated on more than 300 babies and children with a mortality of 8 per cent.

The next great surgical contribution was the successful treatment of another congenital condition called patent ductus arteriosus, consisting of persistent patency of a blood vessel between the aorta and the pulmonary artery. The failure of this embryonic vessel to close at birth produces an enlarged heart, breathlessness and weakness, and other complications later in life. The surgical correction of this failure on nature's part was first performed successfully in 1938 by Dr. Robert Gross of Boston, and the perfection of the technic was achieved in the experimental laboratory.

Finally, I want to mention the surgical treatment of one other congenital anomaly, namely, coarctation of the aorta, which is a condition where there is a persistent narrowing or stricture of the arch of the aorta, so that the patient has high blood pressure in his head, neck and arms, and low blood pressure in his legs, below the constriction. A relatively large number of these individuals were inducted into the Army before their true condition was recognized. This condition was first successfully operated on by Clarence Crafoord, of Stockholm, by excision of the constricted segment and anastomosis of the remaining normal ends. Experimental work was essential to discover whether or not the cut ends of the aorta had enough stretch to enable them to bridge the gap.

SUMMARY

I have touched very briefly on a number of important advances in medicine which have benefited the human race and which were the direct results of experimentation on the anesthetized animal.

In the short time at my disposal, this has been a very sketchy survey, and I apologize for its brevity and omissions. If there is any doubt in your minds as to the value of experiments on anesthetized animals, please do not close this hearing without giving me opportunity to present more complete evidence.

This bill is based on the premise that no good thing whatsoever has come from experiments on animals. I ask you gentlemen, where does the cruelty lie, —with the scientists who humanely use animals to end human suffering, or with the proponents of this bill, who, by stopping animal experimentation, would deny man and animals an indispensable weapon against the scourges of disease that still beset them?

Washington Physicians of Yesterday

WILLIAM HOLLAND WILMER, M.D., LL.D., Sc.D.

One of the most distinguished physicians that Washington has ever had was William Holland Wilmer, who was born in Powhatan County, near Richmond, Virginia, on August 26, 1863, during the tumults of the War between the States. He came from distinguished clerical stock; his grandfather was the first rector of historic Saint John's Church in Washington and later president of William and Mary College; his father was Bishop (of Alabama) Richard Hooker Wilmer; and he has a grandson in the ministry. He was reared near Mobile, Alabama; educated at the Episcopal High School near Alexandria, Virginia, and the University of Virginia, where he received the degree of M.D. in 1885. He then served as an intern in Mount Sinai Hospital, New York City, and became associated with Dr. Emil Gruening, a prominent ophthalmologist.

He practiced ophthalmology in Washington from 1889 to 1925, achieving a distinguished national and international reputation, and numbering among his patients the most eminent people. He was Professor of Ophthalmology at Georgetown University, 1906-1925, and was one of the founders of the Episcopal Eye, Ear, and Throat Hospital in Washington. Commissioned in the Medical Reserve Corps of the United States Army in 1911, he rendered distinguished service in World War I, attaining the rank of Brigadier General. He was a member of numerous medical societies and the recipient of many honors: degree of LL. D., Georgetown University, 1919; honorary Sc. D., Princeton University 1926, New York University 1929; Distinguished Service Medal (United States), 1919; Commander of the Legion of Honor (France), 1924.

(*Continued on page 230*)

LOCAL DOCTORS GAVE OVER A MILLION DOLLARS IN SERVICE

Willard C. Smith
Administrator, Health Security Administration

Much discussion has been heard of late regarding the increased costs of hospital care and of the need for higher rates of payment from the Community Chest, from Group Hospitalization and from the official health and welfare organizations. Health Security Administration's recent annual meeting was reported under the headline, "HSA Reports $454,865 Paid Local Hospitals," but the story went on to report that "it still fell $82,544 short of the amount it contracted to pay." Missing from the headline and unmentioned in the report was the vast amount of medical care which doctors gave to charity patients for whom this nearly half million dollars was paid to hospitals.

Health Security Administration is the central admitting bureau for hospitals in relation to indigent and semi-indigent patients. Money for hospitals is derived from the Community Chest Federation, from the payments by part-pay patients, and, to some extent, from tax funds of nearby political jurisdictions. These nearby Maryland and Virginia counties pay through Health Security Administration for at least a part of the service which hospitals provide to their needy residents. The District of Columbia paid nothing for the nearly $100,000.00 worth of inpatient and outpatient care (exclusive of contract service at Casualty, Children's and Emergency Hospitals) which HSA certified for District of Columbia tax-eligible patients in 1946.

What about the value of doctors' services which the headlines don't mention and the reports don't discuss? During the past year HSA certified 97,964 clinic visits, 9,686 infant days, and 84,772 adult days' care. On all of this service the thousands of patients involved received free medical care. No price is put upon the doctors' professional services and it is therefore impossible for the financial report to reveal the doctors' contribution. Consider, however, just one group of patients, medical and surgical, of which there were 4,853. Consider also just one specific type of case, obstetrical, of which there were 2,222. The doctors who cared for these patients gave precisely the same care with precisely the same skill that all of these patients would have received if they had been private patients in the highest income brackets. Apply any average fee per patient that you choose to these 7,075 patients. Forget, if you please, the thousands of other days' care and the 84,772 clinic visits. Could anyone think for a moment that the doctors' contribution to these Community Chest-HSA-eligible patients was less than a million dollars? Could anyone think for a moment that doctors as a group do not have an interest, indeed a vital stake, in the day-by-day operations of HSA which determine the worthiness or eligibility of these thousands of patients to receive free medical care?

What are the other services which the hospitals, the Community Chest and the doctors provide to sick indigents in our metropolitan community? HSA has the record. Let's look at it.

The accompanying illustration shows a section of the statistical card. One of these cards is made by a medical-social worker for each applicant. Many applicants are "rejected," which is to say that they do not receive cash assistance from either the Community Chest or HSA funds. Nor do they receive free medical care. Many are taught how to budget their accounts so that they can pay in full both hospital and doctor bills. Some learn about facilities in their own county of which they did not know until they applied to HSA. Some are advised to make their own arrangements as pay-patients at some hospital, some are referred to the Permit Bureau of the D. C. Health Department, and many are referred to private physicians of their own choice.*

Many applicants, through HSA's consultation service, learn that their problem can be solved through some service that is available to them through the Government department or the business establishment in which they are employed. Many of our large business concerns, notably the Potomac Electric Power Company and the Washington Gas Light Company, have hospitalization benefits on the basis of insurance. As soon as it begins to operate, HSA will be able to advise some of its applicants how they may obtain service from Medical Service of the District of Columbia, the new prepaid service plan sponsored by the Medical Society.

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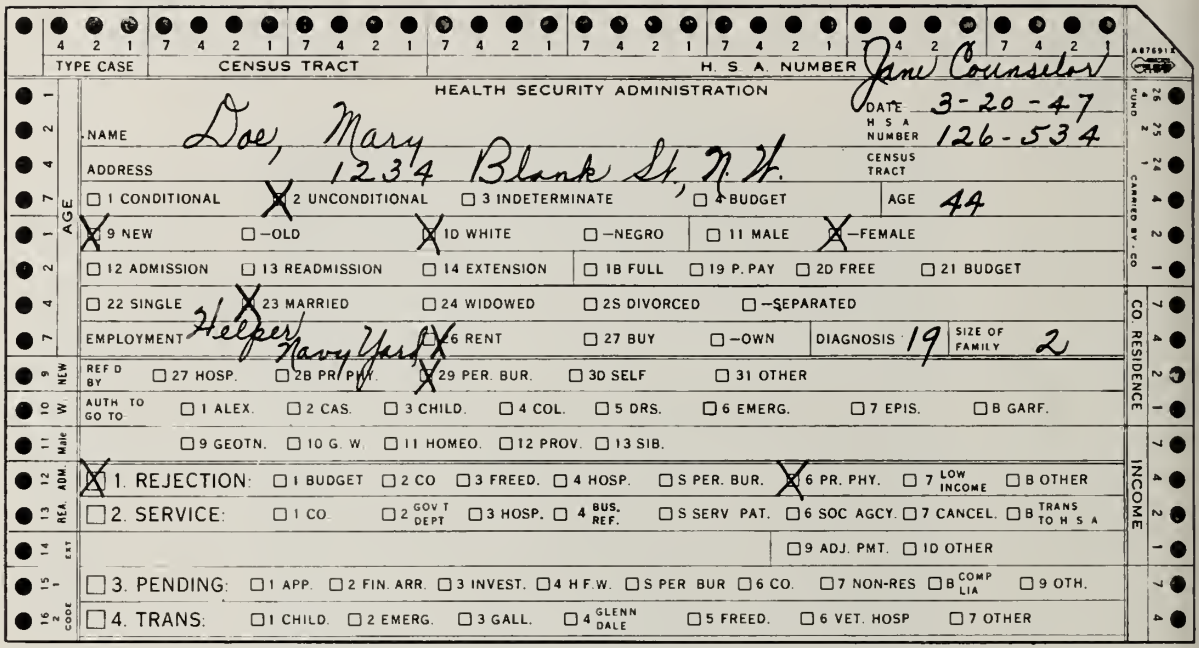
* The telephone switchboard of HSA is connected by direct wire to the switchboard of the Medical Bureau.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AGE
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CO. RESIDENCE
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INCOME
A87691

TYPE CASE CENSUS TRACT H. S. A. NUMBER Jane Counselor

HEALTH SECURITY ADMINISTRATION

NAME Doe, Mary
DATE 3-20-47
H S A NUMBER 126-534
ADDRESS 1234 Blank St, N. W.
CENSUS TRACT
☐ 1 CONDITIONAL ☒ 2 UNCONDITIONAL ☐ 3 INDETERMINATE ☐ 4 BUDGET AGE 44
☒ 9 NEW ☐ –OLD ☒ 10 WHITE ☐ –NEGRO ☐ 11 MALE ☒ –FEMALE
☐ 12 ADMISSION ☐ 13 READMISSION ☐ 14 EXTENSION ☐ 18 FULL ☐ 19 P. PAY ☐ 20 FREE ☐ 21 BUDGET
☐ 22 SINGLE ☒ 23 MARRIED ☐ 24 WIDOWED ☐ 25 DIVORCED ☐ –SEPARATED
EMPLOYMENT Helper Navy Yard ☒ 26 RENT ☐ 27 BUY ☐ –OWN DIAGNOSIS 19 SIZE OF FAMILY 2
REF D BY ☐ 27 HOSP. ☐ 28 PR. PHY. ☒ 29 PER. BUR. ☐ 30 SELF ☐ 31 OTHER
AUTH TO GO TO ☐ 1 ALEX. ☐ 2 CAS. ☐ 3 CHILD. ☐ 4 COL. ☐ 5 DRS. ☐ 6 EMERG. ☐ 7 EPIS. ☐ 8 GARF.
☐ 9 GEOTN. ☐ 10 G. W. ☐ 11 HOMEO. ☐ 12 PROV. ☐ 13 SIB.
☒ 1. REJECTION: ☐ 1 BUDGET ☐ 2 CO ☐ 3 FREED. ☐ 4 HOSP. ☐ 5 PER. BUR. ☒ 6 PR. PHY. ☐ 7 LOW INCOME ☐ 8 OTHER
☐ 2. SERVICE: ☐ 1 CO. ☐ 2 GOV T DEPT ☐ 3 HOSP. ☐ 4 BUS. REF. ☐ 5 SERV PAT. ☐ 6 SOC AGCY. ☐ 7 CANCEL. ☐ 8 TRANS TO H S A
☐ 9 ADJ. PMT. ☐ 10 OTHER
☐ 3. PENDING: ☐ 1 APP. ☐ 2 FIN. ARR. ☐ 3 INVEST. ☐ 4 H F.W. ☐ 5 PER BUR ☐ 6 CO. ☐ 7 NON-RES ☐ 8 COMP LIA ☐ 9 OTH.
☐ 4. TRANS: ☐ 1 CHILD. ☐ 2 EMERG. ☐ 3 GALL. ☐ 4 GLENN DALE ☐ 5 FREED. ☐ 6 VET. HOSP ☐ 7 OTHER

Many of the applicants at HSA need only to be transferred to one of the Government hospital services to which they are eligible or to one of the voluntary hospitals which have a contract with the D. C. Health Department, such as Children's and Emergency.

Much of the service which HSA performs and which is of value to the hospitals, the Community Chest and to the doctors, but which is never evidenced in a financial report, is recorded on the statistical card shown above in the two lines designated, "REJECTION and SERVICE." One case will illustrate.

> A woman was referred by an official case-working agency with a medical recommendation for hospitalization for a condition causing bleeding from the rectum and lungs. This patient might have been sent routinely to a hospital where she would have received free medical care and the hospital would have received only the below-cost rate accepted for Community Chest patients. As a matter of fact, she would have been so referred except for the complete counseling service provided by trained workers at HSA. Here it was discovered that both the patient and her husband had been employed during the War at Pearl Harbor, where, under the restricted living conditions imposed by wartime necessity, they had accumulated savings and war bonds amounting to nearly $10,000.00. Unfamiliar with the health facilities of Washington and having become accustomed to accepting Government-provided medical care, neither husband nor wife felt that they would be receiving charity if they accepted what was apparently easy to obtain without cost to themselves. Interpretation by the medical-social counselor induced a ready acceptance of their own financial responsibility and the patient arranged for her own care through a physician of her own choice. As a matter of fact, the very physician who had recommended hospitalization and who, but for the functioning of HSA's medical-social counseling service, might have seen the patient on staff care without a fee which the family was well able to afford!

Space does not permit a recital of cases illustrating all the types of service which the community receives from the central admission of charity patients. The point is that the fiscal reports which are usually publicized "cannot picture the variety of human suffering alleviated, the anxiety of parents, husbands and wives quieted, and the self respect of poor people sustained or restored by the operations of HSA in administering the dollars therein tabulated."[1]

MEETINGS

Wednesday, May 7

ANNUAL BUSINESS MEETING

Wednesday, May 14

SYMPOSIUM ON DISEASES OF THE THYMUS

This program will be sponsored by the *Section on Pediatrics;* speakers and subjects to be announced.

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[1] Macatee, H. C., M.D.: President's Annual Report, Health Security Administration, March 11, 1947.

DR. RUFFIN RETIRES

The retirement of Dr. Sterling Ruffin, who has occupied such a prominent place upon the stage of medical practice in the District of Columbia for more than a half century, constitutes an event of more than passing moment. Thus we pause in feeble effort to pay him tribute. Gratifying it is to know that his wise decision not to delay too long in resting his heavy burden upon shoulders more youthful was not due to failing health, but that he remains physically vigorous and continues to function as senior Director of the Riggs National Bank.

Born in Graham, North Carolina, the son of Dr. John Kirkland Ruffin and Mrs. Ruffin, formerly Miss Sarah Elizabeth Tayloe of Washington, North Carolina, he came to this city shortly following graduation from the University of that state and entered upon the study of medicine in the Columbian University (now the George Washington University), graduating three years later. Then began the extensive practice that awaited him. Succeeding the late Dr. W. W. Johnston as Professor of Practice in the Medical Department of this University in 1902, he held that chair until 1924, then becoming Professor Emeritus.

To those who have been privileged to know him best, Dr. Ruffin would seem to have been peculiarly fitted, not only hereditarily, but as well by a personality and manly charm, both as teacher and as practitioner. As a medical educator, through the medium of his students the flowers of the seeds of his planting may be found strewn not only throughout our land but far beyond its frontiers.

Sterling Ruffin, M.D.

Faithful across the years to his calling, ministering sympathetically alike to President and to pauper, usually healing, consistently relieving, always comforting, he now rests upon a very high pedestal. Dr. Ruffin's counsel has been widely sought in the consultation chamber, and many of his patients have declared in grateful acknowledgment that his bedside presence was a benediction.

Modern medical trends have occasioned him deep concern, and with every threat of assault upon the high principles of American medicine he has steadfastly declined compromise. Truly his name will long linger upon the leaves of medical memory.

Dr. Ruffin, your fellows of the medical profession salute you, and heartily wish for you continuing health, happiness and length of years.

R. Arthur Hooe, M.D.

THE NEW GEORGE WASHINGTON UNIVERSITY HOSPITAL

As a general hospital, the new George Washington University Hospital, for which there is now a campaign to raise $925,000 for the equipment and furnishings, will contain all of the departments traditionally associated with a large community hospital.

In addition to the traditional services, there will be special facilities for the diagnosis and treatment in the fields of Neuro-Psychiatry and Neurology, Physical Medicine, Radiology, and Maternal and Child Care. Heretofore, patients have had to go out of the city for many of these facilities.

The basic community need for additional hospital beds will be immeasurably aided by the addition of 315 beds. Thus, overcrowding in existing hospitals will be relieved, and patients, in many instances, will now be able to stay hospitalized an adequate length of time.

Typical of the many modern facilities which will be provided in the new Hospital are the following:

Bed Accommodations. A total of 405 urgently needed hospital beds for patients of all economic levels, private, semi-private, and ward bed service, utilizing the latest advances in hospital architectural planning, administration, and equipment.

In order to provide accommodations for the ever-growing number of patients who desire semi-private rooms, the new Hospital will devote 54.82 per cent of its bed capacity to this group, or 111 rooms with two beds to a room.

Sixty-four beds will account for 15.80 per cent of the capacity in three 8-bed wards and ten 4-bed wards.

There will be provision for 119 single beds in private rooms, or 29.38 per cent of the total bed capacity.

Maternal and Infant Care. Architecturally planned to encourage a "mother and child" relationship as natural and intimate as in the home . . . Recognition of the new-born infant as an "individual" . . . some will have a private nursery within the mother's room; others will be cared for in rooms next to the mothers' rooms separated only by glass vision-panels . . . for others the "cubicle" or "group" nurseries of 4- and 8-crib capacity . . . varied facilities allow the mother to exercise virtually as much choice in the selection of a nursery for her baby as in choosing a room for herself . . . the nurseries thus become centers around which the mothers' rooms are planned.

In addition, infant isolation nurseries, as well as similar arrangements for mothers, will be provided to control infections; and . . . a fully air-conditioned premature nursery with piped-in oxygen system . . . specially designed cribs or bassinets to allow wheeling into the mothers' rooms for attachment to the mothers' beds.

X-ray and Radiological. A complete and well-balanced department including: One 250,000-volt Deep X-ray Therapy unit and two 120,000-volt Superficial X-ray Therapy units, so valuable in the diagnosis and treatment of cancer; two Radiographic Fluoroscopic units for diagnostic purposes, including a Miniature Chest Unit attachment for mass X-rays . . . Chest X-rays of all hospital personnel and patients will be standard procedure in the new hospital . . . In addition, there will be two Mobile X-ray units for "bedside radiography," as well as three X-ray Therapy units in the Genito-Urological Department, a Vertical Fluoroscope for the "Heart Station" in the Cardiology Department, and a Dental unit.

Psychiatric and Neurological. In addition to standard facilities, specialized equipment and treatment for alcoholism.

Physiotherapy. Diathermy, short-wave, infra-red, ultra-violet, underwater, continuous-flow and whirlpool baths, enductotherm and fever therapy units.

Heart Station. For prevention and treatment of the number one cause of death, heart disease, a "heart station" will be located in the Medical Division . . . containing the latest diagnostic aids, including two visocardiette units which permit immediate registration of heart impulses on sensitized paper . . . thus eliminating conventional dark-room and developing processes, affording the physician an immediate opportunity for study.

Optical. A special section devoted to "Orthoptics". . . the use of special apparatus by trained technicians giving special muscle exercises and training designed to overcome certain defects and conditions of the eyes.

Laboratories. For blood tests, blood chemistry, urine, and other examinations, plus the Special Experimental Laboratory for medical research through animal injection and diagnosis.

Pharmacy. With solution, compounding and man-

(*Continued on page 230*)

REPORT OF THE EXECUTIVE BOARD*

Usually, only urgent matters are taken up at special business meetings of the Society. There are exceptions to this rule, one being the annual membership and financial reports, which would be very much out of date if held for presentation until the Annual Business Meeting in May. Some routine matters which could not be disposed of during the organization year if not presented at this meeting are also included. Wherever possible, however, business matters are held until the Annual Business Meeting, when the Board renders an account of its stewardship and reviews the activities of all the Society's committees.

Rear Admiral Clifford A. Swanson Proposed for Honorary Membership: Most of our members are familiar with the fact that Rear Admiral Swanson was sworn in as Surgeon General of the Navy and Chief of the Bureau of Medicine and Surgery on December 2, 1946, succeeding Vice Admiral Ross T. McIntire.

Admiral Swanson is widely recognized for his outstanding work in ophthalmology and otolaryngology. During the War he was engaged in research in color vision and night vision. He made studies of the effect of increased barometric pressure on the eye which were of tremendous value in deep-sea diving. He also made tabulations of oxygen consumption under varied barometric pressures, which were valuable in the aviation field. Few physicians have attained Admiral Swanson's eminence at his age.

Our Society has conferred Honorary memberships on the present Surgeon General of the Army and Surgeon General of the U.S. Public Health Service because of their outstanding contributions to medical science, and the high office to which they have been appointed. Admiral Swanson's predecessor was also so honored. Your Board believes equal recognition should be given Admiral Swanson, and, therefore, proposes him for Honorary membership. As provided by the Constitution and By-laws, this proposal will be referred to the Board of Censors for its immediate consideration.

Proposed Amendment to the Constitution and By-laws: Under date of January 3, 1947, thirty-two Washington anesthetists petitioned the Executive Board to initiate steps to amend the Society's Constitution and By-laws creating a Section on Anesthesiology. The Board was pleased to grant this request and submits herewith the following amendment:

Amendment XIII

Section 1, Article II of Chapter IX of the Constitution and By-laws is hereby amended by adding thereto the following:

Section 6, on Anesthesiology

The above amendment cannot be voted on until the next business meeting. It will therefore be presented to the Society for final action at the Annual Business Meeting on May 7.

Summary of Membership for 1946: According to the annual membership report for 1946, the Society had 1,235 members of all classifications on January 1, 1946. This had increased on the last day of the year to 1,335, or an even 100 members. A most significant fact is that the largest increase was in Active membership, there being 946 at the beginning of the year, and 1,028 at its close, or an additional 82 Active members.

It might be added that since the annual report was prepared, there have been 127 applicants elected, of which 113 were Active members. Applications are still being received, and it is estimated that the total membership may run well over 1,500 before the end of 1947.

Annual Financial Report for 1946 and Budget for 1947: [Space limitations will not permit the publication of the Report and the Budget. Members who are interested and could not attend the Business Meeting at which they were presented can obtain copies by calling the Society's office.]

Health Security Administration: In a recent letter addressed to the Society, Dr. Henry C. Macatee, President of Health Security Administration, called attention to the differences which had arisen in drafting a new agreement between HSA and hospitals in the Washington Metropolitan Area. Recently a draft was prepared and submitted to HSA by the newly organized Hospital Council of the National Capital Area. This agreement, it was proposed, should supplant a previous HSA-Chest-Hospital agreement because of ambiguities of language which led to controversies with local hospitals. The paragraph in the old agreement which resulted in differences of opinion read:

"All persons to whom the Hospitals shall furnish clinic services or shall furnish hospitalization with free medical care, on a part-payment or no-payment basis, shall be required to apply in advance to HSA for investigation and certification, with the exceptions hereinafter stated."

The proposed new agreement contains the following paragraph:

"All persons to whom the Hospitals shall furnish clinic services or hospitalization with free medical care, on a part-payment or no-payment basis, *for which care reimbursement from the Chest is to be requested by the Hospital*, shall be required to apply in advance to HSA for certification. . . ."

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* Adopted at a special Business Meeting of the Society, March 5, 1947.

The italicized words, it is claimed, would limit the investigative function of HSA. It would permit those persons who are able to pay Chest rates or better, to go directly to the hospitals—"investigation of the worthiness to receive free medical care becomes the independent function of the hospitals."

In the opinion of the Medical Society representatives to HSA, Dr. Macatee said, this paragraph would serve to cancel the object of the Medical Society and the organization of HSA. Knowing of the determination of hospitals to secure the adoption of the paragraph proposed by the Council, HSA had formulated the following paragraph:

"Each hospital will transmit to HSA, on forms to be agreed upon, such information for each individual who is given clinic care or hospital care with free medical service, other than on certification by HSA, as is required by HSA for its own certification; the same to be used for statistical purposes concerning the indigent or partly indigent community load; except that in the discretion of the hospital, such information may be omitted when such care is provided as part of a compensation agreement with its staff and employees and with those groups, such as the clergy, to which it has Charter obligations."

Medical representatives to HSA unanimously approved the above paragraph, but by a vote of fourteen to two, these representatives recommended that the Medical Society should endorse the elimination of the words "for which care reimbursement from the Chest is to be requested by the Hospital."

Your Board recommends that the Society approve the recommendation of its representatives to HSA.

Washington Metropolitan Health Council's Survey: At the last Annual Business Meeting Dr. William C. Woodward introduced the following resolution:

"Resolved, That the Executive Board be and is hereby requested (1) to submit to the Society as soon as practicable, and not later than June 30, 1946, an objective analysis of the report made public by the Metropolitan Health and Hospital Survey April 30, 1946, on hospitals and medical services in the District of Columbia; (2) to submit with that analysis detailed recommendations for such action by the Society as the Executive Board deems proper; and (3) to send a copy of its analysis and recommendations to every member of the Society not less than ten days before the meeting of the Society at which they are to be submitted."

It has been impossible to carry out the provisions of this resolution within the period prescribed. Even at this late date, only a portion of the report of the investigators for the Washington Metropolitan Health Council has been reviewed by the Council's Survey Committee. It was, therefore, recommended by the Committee on Public Policy, to whom this resolution was referred, that the Society be notified of the impossibility of complying with Dr. Woodward's resolution, and that it might still be many months before any recommendations can be submitted.

Your Board, being fully cognizant of the situation which exists, believes the Society will accept this explanation, allowing the matter to rest for the time being.

Election of Nominating Committee: Your Board is pleased to announce that more than 500 members voted in the election of a Nominating Committee. It will be recalled that twenty-one names were listed on the ballot and those receiving the seven highest number of votes would serve as a committee. It was also understood that in the event any member elected could not serve, the individual receiving the next highest number of votes would automatically become a member of the committee.

The following were elected to the committee and are reporting to you tonight: Drs. Harry H. Kerr, Joseph S. Wall, Victor R. Alfaro, Robert J. Coffey, Charles P. Howze, Paul S. Putzki, and Don S. Knowlton.

In a recent letter your attention was called to the fact that additional nominations can be made from the floor, but that the Nominating Committee will submit only one nominee for each office. The Society's Constitution and By-laws requires that all nominations must be made on the first Wednesday in March, and cannot be made after that time, except in the event of death or withdrawal of a nominee.

Recommendations of Cancer Control Committee: At a meeting of the Society on October 23, 1946, the proposal was made that the Society coöperate with the District Health Department in a cancer survey. As this item was not on the agenda mailed to members and it was rejected, no further action was taken. Rejection was due primarily to the fact that physicians were required to furnish the names of their patients having a cancer.

This matter has again come before the Board, it being now recommended by the Society's Committee on Cancer Control that the Society coöperate with the Washington Division of the American Cancer Society in a survey of living cancer cases in the District of Columbia. The Board believes it has a better understanding of what is contemplated in such a survey, and is prepared to recommend again that the Society lend its coöperation.

At a meeting of the Board held on February 24, 1947, Dr. Harry H. Kerr, President of the District of Columbia Division of the American Cancer Society, and Dr. Harold F. Dorn of the National Cancer Institute, both of whom are speakers on the program this evening, together with Dr. Roger M. Choisser and Dr. Calvin T. Klopp, Medical Director of the Warwick Cancer Clinic, were present for the purpose of discussing the contemplated survey. Full assurance was given that names of cancer cases provided by physicians would be kept strictly confidential. In fact, it was stated that the only purpose in requesting the use of names was to avoid duplication. As soon as the data from the forms have been tabulated, it was agreed that they would be turned over to the Medical Society for destruction or to be placed in its archives.

There can be no question as to the value of the survey proposed. This is attested to by the fact that similar surveys have been undertaken in most large cities of the country in coöperation with local county medical societies. The District Society would, therefore, not be setting a precedent.

With regard to the legal right of physicians to provide the names of cancer patients, this has been determined in several jurisdictions. In one state an attorney general ruled that as such reports would be made directly to government agencies which would maintain secrecy, there would be no violation of the law.

Your Board urges you to indorse the proposed survey of cancer cases and that you individually coöperate wholeheartedly in the undertaking.

Conclusion: As previously stated, a comprehensive report will be prepared for the Annual Business Meeting of the Society in May. At that time there will also be further discussion of some of the plans for the future. There are a number of projects in the making in which all members are vitally interested.

Respectfully submitted,

A. Magruder MacDonald, M.D., *Chairman*
William M. Ballinger, M.D.
William Earl Clark, M.D.
Coursen B. Conklin, M.D.
William P. Herbst, Jr., M.D.
Raymond T. Holden, M.D.
Fred R. Sanderson, M.D.
Theodore Wiprud, *Secretary*

NOMINATIONS

The following nominations for elective offices were presented by the Nominating Committee at the business meeting of the Medical Society on March 5, 1947:

For President-elect
John Minor
For First Vice President
Ivy A. Pelzman
For Second Vice President
Carolyn Pincock
For Member of Executive Board
William P. Herbst, Jr.
For Member of Board of Censors
W. Ross Morris
For Member of Board of Censors to succeed Harry F. Dowling, resigned
William W. Chase
For Delegate to American Medical Association
Coursen B. Conklin
For Alternate Delegate to American Medical Association
Worth B. Daniels
For Alternate Delegate to American Medical Association to succeed Harry F. Dowling, resigned
J. Lawn Thompson, Jr.

No additional nominations were made from the floor. Elections to the above offices will be held at the annual business meeting, May 7, 1947.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, March 24, 1947, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society.

Active Members

Albert A. Ackerman, 2810 O Street, S. E.
Lester John Dugan, 7 Girard Street, N. E.
Lester I. Fox, 1400 South Barton Street, Arlington, Va.
John P. Gallagher, 2002 R Street, N. W.
Frederick B. Hartsock, 2505 13th Street, N. W.
Spencer V. Meade, 4 Berkley Street
Erwin Pesé, 2529 Pennsylvania Avenue, N. W.
Robert Douglas Ralph, 1328 Eye Street, N. W.
Hugo V. Rizzoli, 2025 Eye Street, N. W.
David H. Rosenfeld, 1826 Harvard Street, N. W.
Alexander Tish, 2701 Connecticut Avenue, N. W.
Raymond J. Winfield, 4725 10th Street, N. E.
Thomas C. Worth, 1835 Eye Street, N. W.

Associate Members

Frank G. Leslie, 8248 Georgia Avenue, Silver Spring, Md.
George N. Schultz, 9410 Worth Avenue, Silver Spring, Md.

The following applicants for membership will be voted on at the meeting of the Executive Board, May 26, 1947:

For Active Membership

Theodore R. Coleman, University of Louisville—1928
Reginald A. Cutting, McGill University—1923
Julius D. Damian, Georgetown University—1930
John James Kuhn, Georgetown University—1938
James Walling Long, George Washington University—1943

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News and Personals

Approximately 5,000 requests for advance registration cards for the **AMA Centennial Convention** have been received, according to Mr. A. W. Stack, Director of Membership, Fellowship and Subscription. He states that registration identification cards will be mailed about 30 days before the session. Fellows who wish to register in advance should send their requests to Mr. Stack as soon as conveniently possible. Those Fellows who do not wish to register in advance may register, as heretofore, at the time of the session. Members of the House of Delegates and Officers of the Association may register at the Traymore Hotel.

The 13th Annual Meeting of the American College of Chest Physicians will convene at the Ambassador Hotel, Atlantic City, N. J., June 5 to 8.

The oral and written examinations for fellowship will be held on the first day of the meeting, June 5. Applicants for fellowship in the College who plan to take these examinations should communicate at once with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Convocation for new fellows and life members of the College will be held on Sunday, June 8. At this time certificates will be awarded to fellows and life members admitted since June 1946.

A conclave of combined professional personnel in industrial health work over the entire Nation will take place the week of April 26–May 4 at the Hotel Statler, Buffalo, New York, where the following meetings will be held: the 32nd Annual Convention of the American Association of Industrial Physicians and Surgeons; the 9th Annual Conference of the American Conference of Governmental Industrial Hygienists; the 8th Annual Meeting of the American Industrial Hygiene Association; the 5th Annual Conference of the American Association of Industrial Nurses; and the 4th Annual Meeting of the American Association of Industrial Dentists.

A copy of the preliminary program may be secured by writing to Dr. Edward C. Holmblad, Managing Director, AAIPS, 28 East Jackson Blvd., Chicago 4, Ill. All hotel reservations are made by the Housing Bureau, Buffalo Convention and Tourist Bureau, Inc., 602 Genesee Bldg., Buffalo, N. Y.

CALENDER OF MEETINGS

March 3	Committee on Public Relations
	Nominating Committee
	Subcommittee on Tuberculosis
	Ways and Means Committee, Woman's Auxiliary
	Washington Ophthalmological Society
March 4	District Unit, American Diabetes Association
March 5	Business Meeting of Society
March 6	Section on Neurology and Psychiatry
	Washington Metropolitan Health Council
March 8	Washington-Baltimore Psychoanalytic Society
March 9	Washington-Baltimore Psychoanalytic Society
March 10	Washington Orthopedic Society
	Executive Board, Woman's Auxiliary
March 11	Section on Anesthesiology
	Subcommittee on Public Health Exhibits, Annual Scientific Assembly
March 12	Scientific Meeting of Society
	Woman's Auxiliary
March 14	Committee on Special Events
March 17	Grievance Committee
March 18	Membership Committee
March 19	Committee on Postgraduate Education
March 20	Board of Censors
March 24	Executive Board
March 25	Physician-Veterans of World War II
March 26	Scientific Meeting of Society
	Washington Gynecological Society
March 27	Interprofessional Conference

The Executive Board, at its meeting, February 24, appointed the following members to act as a subcommittee for selecting the Davidson Lecturer for 1947; Dr. William P. Herbst, Chairman; Drs. William Earl Clark, William M. Ballinger, Fred R. Sanderson and Raymond T. Holden.

On January 27, the Board gave approval to a plan submitted by the Committee on Public Relations whereby the committee would be enlarged to allow a representative of each medical specialty to be included. Matters of public information coming to the attention of the committee could then be referred to the specialist in the field of medicine appertaining thereto.

In accord with this action President Herbst made a number of additional appointments to this committee, which is now comprised as follows:

Dr. Walter R. Stokes, *Chairman;* Dr. Valentine Hess, Vice *Chairman;* Drs. William W. Chase, Aaron Gerber, Clayton Hixson, Edward Nicklas, John T. Schnebly, *members at large;* Hugh O. House, *allergy;* Joseph B. Bogan, *anesthesia;* Ludwig G. Lederer, *aviation medicine;* Lee McCarthy, *dermatology;* William H. Jenkins, *otolaryngology;* William Earl Clark, *internal medicine;* Roger M. Choisser, *neoplastic diseases;* James P. Murphy, *neurology;* Herbert P. Ramsey, *obstetrics and gynecology;* Sterling Bockoven, *ophthalmology;* William J. Tobin, *orthopedic surgery;* Oscar B. Hunter, Sr., *pathology and laboratory medicine;* William S. Anderson (William A. Howard, alternate), *pediatrics;* Isadore Levin, *physical therapy;* J. Gordon Bell, *plastic surgery;* Robert H. Groh, *psychiatry;* Benjamin F. Dean, Jr., *surgery;* Charles P. Howze, *urology and venereal disease;* Claude Moore, *X-ray and radium;* R. Lomax Wells, *industrial medicine.*

The first meeting of the Board of Directors of **Washington Diabetes Association, Inc.,** a newly organized affiliate group of the national association, was held on March 4 in the Medical Society's building. The Board is made up as follows: Drs. Samuel Benjamin, Robert Hare, Dorothy Jaeger-Lee, DeVoe Meade, K. Hammond Mish, John A. Reed, E. Clarence Rice, Joseph T. Roberts, and J. Ross Veal, all members of the American Diabetes Association; Colonel Arden Freer, of the Veterans Administration; Miss Louise Hagel, of the American Dietetic Association; Mr. Joseph Irvine, D. C. Health Department; Dr. Theodore Koppanyi, Georgetown University School of Medicine; Dr. Lewis Meriam, Brookings Institution; Dr. Joseph Roe, George Washington University School of Medicine; Miss Helen Smoot, Graduate Nurses' Association; and Dr. Hugh L. Wilkerson, U. S. Public Health Service.

The Association has been established for educational and scientific research purposes. It consists of two sub-groups, the Clinical Society and the Lay Society.

The Clinical Society will classify its members as fellows and associate members. A fellow shall be any qualified, licensed practitioner in the Washington Metropolitan Area who is a member of the Medical Society of the District of Columbia, or the state or county (medical) society in which he resides. Also eligible for fellowship are physicians of the military service residing in the Washington Metropolitan Area; physicians from other governmental departments who may be interested in diabetes; and scientific research workers in any field of medicine or its allied sciences who are interested in the subject of diabetes. Associate members shall consist of dietitians, laboratory technicians, nurses and social workers.

The Lay Society shall consist of the diabetic patient, relatives of the diabetic patient interested in the subject of diabetes, and any other layman interested in the subject of diabetes who shall be found through proper investigation to be so interested.

By-laws for the organization were adopted at the meeting and the following officers elected:

Dr. John A. Reed, *President;* Dr. E. Clarence Rice, *Vice President;* Dr. J. Ross Veal, *Secretary-Treasurer;* Dr. Joseph T. Roberts and Colonel Arden Freer, *members of the Executive Committee.*

On May 5 the **Silver Spring Academy of Medicine** will hold its last meeting of the 1946–47 season. Dr. Roscoe R. Spencer, Chief of the National Cancer Institute, will speak on "Recent Research Work in Cancer." Dr. Eugene R. Whitmore, Secretary of the American Association for the Study of Neoplastic Diseases and Director of the Department of Parasitology and Pathology of Georgetown University School of Medicine, will lead the discussion.

The International Medical Club held a luncheon meeting, February 4, in honor of His Excellency Oscar Ivanifsevich, Ambassador of Argentina. The meeting was also the annual business meeting of the Club. New officers were elected as follows:

Dr. George C. Ruhland, *President;* Dr. William P. Herbst, *1st Vice President;* Dr. A. B. Coulter, *2nd Vice President;* Dr. Earl G. Breeding, *3rd Vice President;* Dr. P. S. Constantinople, *Secretary-Director;* Dr. Fred A. J. Geier, *Secretary;* Dr. Joseph Horgan, *Treasurer;* Dr. Henry L. Darner, *Historian.*

At its regular meeting, March 15, the **George Washington University Medical Society** presented the following program in which all the speakers were members of the medical staff of Mt. Alto Hospital:

"Presentation of Two Cases—Streptomycin Therapy in Tuberculosis," Dr. Thomas McP. Brown, Chief of the Medical Service
"Three Cases Demonstrating Interesting Problems in Urological Diagnosis," Dr. Herbert A. Goldberg, Urologist
"Three Cases of Lumbo-Dorsal Sympathectomy for Hypertension," Dr. William S. McCune, Attending Surgeon
"Cineplastic Amputation—Presentation of Two Cases," Dr. Leonard T. Peterson, Attending Consultant in Orthopedics
"Thoraco-Abdominal Approach to Esophago-Gastrectomy—Presentation of One Case," Dr. Vincent M. Iovine, Chief of the Surgical Service

The papers were summarized by Dr. Robert J. Coffey, who is a senior consultant at the Hospital.

The Washington Medical and Surgical Society met on March 24 at the Hotel Statler. Case presentations were made by Dr. William M. Clopton and Dr. T. Frazier Williams.

The Washington Branch of the Pan American Medical Club held its annual meeting and election of officers, February 25, 1947. The guest speaker, Dr. Salvador Hernandez from Guatemala, who is studying in the United States on an Inter-American Affairs grant, discussed "The Hospital and the Community."

The officers elected were as follows:

Dr. A. B. Coulter, *President;* Dr. Watson W. Eldridge, *1st Vice President;* Dr. Charles H. McEnerney, *2nd Vice President;* Dr. Paul F. Dickens, *Secretary;* Dr. William P. Herbst, *Treasurer.*

The regular meeting of the **Clinico-Pathological Society** was held at the Kennedy-Warren Apartments, March 18. Dr. Lewis C. Ecker was host. The following case reports were presented: "Kala Azar," Dr. Worth B. Daniels; "Fenestration Operation for Otosclerosis," Dr. W. H. Jenkins.

The Washington Ophthalmological Society held a special meeting with the Ophthalmological Section of the Baltimore City Medical Society at the Stafford Hotel in Baltimore, March 27. Following dinner the guest speaker, Dr. Raymond L. Pfeiffer, of New York City, gave an address on "Pathologic Changes in the Orbit."

The Kober Lecturer for 1947, Thomas Parran, M.D., ScD., LL.D., Surgeon General of the United States Public Health Service, delivered his address on "Research and Total Health" in Gaston Hall, Georgetown University, March 28, the birthday anniversary of the founder and endower of the Lecture, Dr. George Martin Kober. The Lecturer was selected this year by the Executive Board of the Medical Society of the District of Columbia, in accord with an established custom, in recognition of Dr. Parran's contribution to research.

Dr. Parran is a graduate of Georgetown University, receiving his degree in medicine in 1915. He has had a notable career in the United States Public Health Service, which began in 1917, assuming its highest office, that of Surgeon General, in 1936.

The honorary degrees of Doctor of Laws and Doctor of Science have been conferred upon him by a number of universities and colleges; he is an Honorary Fellow of the Royal Sanitary Institute and the Royal Institute of Public Health and Hygiene (England); an Honorary member of the Medical Society of the District of Columbia; a Fellow of the American Medical Association, the New York Academy of Medicine, the Washington Academy of Medicine, and the American College of Surgeons. He is a Fellow and member of the Board of Governors of the American College of Physicians. He also holds membership in many other scientific organizations. He has received a number of awards, including the Sedgwick Medal of the American Public Health Association and the William Freeman Snow Award of the American Social Hygiene Association. He is a member of the Editorial Board of the *American Journal of Venereal Diseases*, author of "Shadow on the Land," and co-author of "Plain Words about Venereal Diseases."

Previous to the Lecture, Dr. William P. Herbst, President of the District Medical Society, entertained at a buffet supper at his home in honor of Dr. Parran.

The appointment of 27 senior consultants and 22 attending surgeons to serve with the medical staff of **Mount Alto Hospital** has just been announced. The physicians were recommended by the Washington Deans' Committee with the approval of Dr. Charles M. Griffith, Manager of the Veterans Hospital.

The following physicians were appointed as senior consultants:

Bacteriology: Leland Parr
Clinical Laboratories: Roger M. Choisser and Charles Geshickter
General Surgery: Daniel L. Borden and Robert J. Coffey
Gynecology: Jerome F. Crowley and Russell McNitt
Internal Medicine: Roy D. Adams, Worth B. Daniels, Clayton B. Ethridge and Hugh H. Hussey
Neurosurgery: O. Hugh Fulcher and James W. Watts
Ophthalmology: Sterling Bockoven, Edward J. Cummings and G. Victor Simpson
Orthopedic Surgery: Custis Lee Hall and Edward Larkin
Otorhinolaryngology: Don S. Knowlton and Daniel B. Moffett
Plastic Surgery: William C. Meloy
Radiology: Fred O. Coe
Thoracic Surgery: Edgar W. Davis and Russell K. Hollingsworth
Urology: William P. Herbst, Charles P. Howze and Frederick A. Reuter

Attending specialists appointed were:

General Surgery: Walter Atkinson, Thomas Bradley, Crenshaw D. Briggs, Richard L. Jackson, William S. McCune and George A. Resta
Gynecology: J. Keith Cromer and Stafford W. Hawken
Internal Medicine: Aloysius J. B. Connolly, William T. Gibb, Jr., Clarence Hartman, Robert Stolar, J. Lawn Thompson, Joseph J. Wallace, Paul R. Wilner, and Louis K. Alpert (part-time)
Neurology: Paul Chodoff
Neurosurgery: Hugo V. Rizzoli
Orthopedic Surgery: Paul J. O'Donnell and Leonard T. Peterson
Physical Medicine: Robert F. Dow
Urology: William D. Jarman

The departments of Obstetrics and Gynecology at **Georgetown University School of Medicine** will be combined under a full-time director, **Dr. A. A. Marchetti,** as of July 1, according to an announcement by the Very Reverend Lawrence C. Gorman, S.J., President of the University. Retiring on July 1 are two part-time department heads, **Dr. J. J. Mundell,** who heads the Obstetrics Department, and **Dr. Leon A. Martel,** head of the Gynecology Department. Both will remain on the medical staff.

Dr. Marchetti is a native of Richmond and a graduate of the University of Richmond. He received his degree in medicine from Johns Hopkins University in 1928. At present he is Assistant Professor of Obstetrics and Gynecology at Cornell University Medical College.

Four additional appointments to the staff of Georgetown University School of Medicine have also been announced:

Dr. Murray M. Copeland will be head of the Department of Radiology and Professor of Oncology. He comes to Georgetown University from the Veterans Administration hospital in Memphis, Tenn., where he was Chief of Surgery. He has been associated with the faculties of Johns Hopkins and Maryland Universities in the field of oncology.

Dr. Willy Baensch has been named Professor of Roentgenology. In 1926 Dr. Baensch was appointed Instructor of Radiology and Cancer Research at the University of Leipzig, and from 1929 to 1945 he held the position of Director of the Cancer Hospital at the University. In 1934 he was President of the X-ray Congress of Europe.

Dr. Norman Q. Brill has been appointed Director of the Department of Neurology and Professor of Neurology. He was chief of the psychiatric branch in the office of the Surgeon General during his service in the Army. He has recently served the Veterans Administration as consultant and assistant chief in neuropsychiatry.

Dr. Robert F. Dow will head the new Department of Physical Therapy and serve as an Associate Professor of Medicine. He was director of the physical and fever therapy department at St. Joseph's Hospital, Paterson, N. J., before he entered the Army in 1942; upon his release he was appointed Chief of Physical Medicine and Physician-in-Chief of Medical Rehabilitation of Veterans Administration.

Dr. Donald Anderson, Dean of the Boston University School of Medicine, has been selected **Secretary of the Council on Medical Education and Hospitals of the AMA** to succeed Dr. Victor Johnson, resigned. He will assume his new duties as Secretary about July 1.

The American Cancer Society, successor to the American Society for the Control of Cancer, announces the publication of two new journals in the field of neoplastic diseases. *Cancer News,* which was inaugurated with the January 1947 issue, copies of which have been received in the Medical Society's offices, is published for the laity; *Cancer,* a professional journal for distribution to the medical profession, is scheduled for publication in the late summer. The Society's new offices are located at 47 Beaver Street New York 4, N. Y.

At a meeting of the **Hospital Council of the National Capital Area,** February 19, the following officers were reëlected: William R. Castle, President of Garfield Hospital, *President;* Robert G. Whitton, Administrator of Alexandria Hospital, *Vice President;* Sister Marie, Administrator of Providence Hospital, *Secretary;* and Mrs. Walter E. Perry, Vice President of Suburban Hospital, *Treasurer.*

Chosen for three-year terms on the Executive Committee were Francis J. Eiseman, Garfield Hospital; Colonel N. L. McDiarmid, Columbia Hospital; Dr. Alvin R. Sweeney, Gallinger Hospital; and Dr. Montgomery Blair, Children's Hospital. Elected for one year were Charles E. Burbridge, Freedmen's Hospital; S. T. Porter, Casualty Hospital; and Dr. John Orem, Sibley Hospital. Continuing as members of the Committee are Henry P. Blair, Episcopal Hospital; J. G. Capossela, Emergency Hospital; Leo G. Schmelzer, George Washington University Hospital; Arthur B. Solon, Suburban Hospital; and Karl H. York, Arlington Hospital.

Secretary of the Navy James Forrestal has authorized the **Bureau of Medicine and Surgery** to suspend the professional examination of candidates for appointment to the regular Navy Medical Corps in the grade of Acting Assistant Surgeon. Determination of applicants' qualifications will henceforth be based on physical examination, personal interview, and a review of the credentials of their officially compiled records.

Under present plans all phases of procurement processing, including physical examination, interview and compilation of credentials, will be accomplished by the offices of Naval Officer Procurement and their branches.

A Board convened in the Navy Department will review the reports and credentials submitted by the Procurement Offices and make final determination as to the physical and professional qualifications of candidates. Successful candidates will be notified of their selection by the Bureau of Naval Personnel.

Suspension of the professional examinations as a part of the qualification procedure for appointment in no way lessens the standards prescribed for those applying for appointments as Acting Assistant Surgeons in the Navy Medical Corps nor does it in any manner affect the professional examinations required of candidates for appointment to the grade of Assistant Surgeon following completion of internship.

The revised procurement procedure does not alter the provision that candidates must have completed the third year of medical school in order to establish eligibility to apply for appointment as Acting Assistant Surgeon.

On January 27 the **Association of Honorary Consultants to the Army Medical Library** was incorporated under the laws of the District of Columbia. It will continue in its present capacity as an advisory body to the Surgeon General in matters pertaining to the Army Medical Library.

The Association is an outgrowth of an advisory board of outstanding physicians and librarians appointed by General Patterson in 1931.

In 1943 Major General Norman T. Kirk, The Surgeon General, appointed additional consultants and during the following year the Association met as a group. The number has steadily grown and today there are over 85 members. The Association is financed by the Rockefeller Foundation under the auspices of the American Library Association.

The Army Medical Library advises that its photoduplication service, which supplied millions of pages of microfilmed medical articles to the armed services and other research agencies during the War, is now generally available for civilian physicians, institutions and research workers on a cost basis. This means direct access to the Library's enormous resources of medical literature.

A fee of 50 cents is charged for filming any periodical article in a single volume, regardless of length. Microfilming from monographs is furnished at 50 cents for 50 pages or fraction thereof. Photostats are also available at a charge of 50 cents per 10 pages or fraction thereof. Material filmed is not for reproduction without permission of the copyright owner.

For convenience and to keep bookkeeping costs down, a coupon system has been established. Users may buy any quantity of photoduplication coupons at 50 cents each. Order blanks are available upon request. Checks should be made payable to the Treasurer of the United States and sent to the Army Medical Library, 7th Street and Independence Avenue, S.W., Washington 25, D. C.

Announcement has been made of the opening of the **Yater Clinic,** which is located in the Kedrick Building at 1801 K Street, N.W. Members of the staff of the Clinic are as follows:

INTERNAL MEDICINE: Dr. Wallace M. Yater, Director of the Clinic and Chief of Internal Medicine; Drs. Joseph M. Barker, Bernard E. Nunez, Bertram F. Schaefer and Joseph J. Wallace.
DERMATOLOGY AND SYPHILOLOGY: Dr. Edwin E. Barksdale
PEDIATRICS: Dr. Catharine Knop
PHYSICAL MEDICINE: Dr. Gervase J. P. Barger
GENERAL SURGERY: Dr. Robert J. Coffey
GYNECOLOGY AND OBSTETRICS: Drs. Carlton N. Price and Albert S. MacMillan
UROLOGY: Dr. Leon R. Culbertson
ORTHOPEDIC SURGERY: Dr. T. Wylie Hodges
PROCTOLOGY: Dr. Vincent T. Young
OPHTHALMOLOGY: Dr. William H. Hanna
OTOLARYNGOLOGY: Dr. Joseph M. Daly
ROENTGENOLOGY: Dr. Eugene McDonald
BUSINESS ADMINISTRATOR: Mr. Herman Brumfield

Major General Norman T. Kirk, Surgeon General of the Army, was one of eleven high ranking military leaders, chosen to represent America's effort in World War II, upon whom Columbia University conferred the honorary degree of Doctor of Laws. The presentation was made at a special convocation held at the Low Memorial Library of the University on February 21. Dr. Frank D. Fackenthal, Acting President of the University, officiated at the ceremonies.

The citation honoring General Kirk stated that he "led the campaign against the hazards of battle; using every resource of speed and skill and research to preserve the lives and restore the health of fighting men; a soldier warring upon disease and disaster, and gaining an unprecedented, an almost unbelievable victory."

General Kirk addressed the Boston Orthopedic Club, February 17, and showed two films entitled, "Therapeutic Exercise" and "Convalescent Care and Rehabilitation of Patients with Injury to Spinal Cord."

Dr. Roy Lyman Sexton accompanied officials of the Department of the Interior on an extensive survey of the islands of the Southwest Pacific. The survey was made to plan for civilian government and some measure of self-government for the islands that are now under military supervision. Dr. Sexton participated in the expedition as medical adviser. Included in the survey were 76 islands belonging to the United States and something under 600 islands which formerly belonged to Japan. The population of the U. S. zone is something around 80,000, and of those previously under Japanese mandate, something under 100,000, exclusive of Okinawa, which has 400,000 natives.

The party left by plane on February 16 and returned March 5. The itinerary included the islands of Hawaii, Canton Island, American Samoa (Pago Pago), Kwajalein, Guam and Okinawa; Shanghai, China; and the entire length of Japan from Nagasaki to Tokyo. On the return trip stops were made at Wake Island, Hawaii, San Francisco and Los Angeles.

In commenting on this mission, Dr. Sexton stated, "If our American form of government is to survive, these people must be shown the advantages that go with some degree of self-government. If we are at all lax in promoting this education, other nations are ready to step in and take over."

Dr. Aubrey O. Hampton of Washington, D. C., and Dr. H. B. Williams of New York City have been appointed by the Board of Trustees of the American Medical Association to represent the AMA on the National Committee on Radiation Protection of the National Bureau of Standards.

Dr. Harold Lester Hirsh has been assigned to the staff at the Rapid Treatment Center at Gallinger Hospital to conduct studies evaluating the new drug, streptomycin.

Dr. Hirsh is a graduate of Maryland University and the Georgetown University School of Medicine. For the past two years, as a fellow in medicine at the

George Washington University School of Medicine, he has been engaged in clinical research in antibiotics. He has been doing part-time work in the Bureau of Venereal Diseases since July, 1945.

Dr. Sterling V. Mead, President of the American Dental Association, spoke at the opening luncheon, March 10, of the District of Columbia Postgraduate Clinic, sponsored by the Dental Society. He stressed the importance of securing grants-in-aid to promote dental research. A national program for the care of school children similar to that operating in the District was also suggested by him. Dr. Mead is an Associate Member of the Medical Society.

Dr. Edward J. Stieglitz fulfilled two out-of-town speaking engagements during the month of March. He gave a talk on "The Effects of Aging on the Individual" at the Conference on Health in an Aging Population, in Rochester, New York, on March 13.

On March 19, at the opening session of a three-day Institute on Social Medicine, Dr. Stieglitz spoke on "The Integration of Clinical and Social Medicine." Other speakers at the Institute, which marked the Centennial Celebration of the New York Academy of Medicine, were Professor John Ryle, of Oxford University, Dr. Jonothan C. Meakins, Professor of Medicine at McGill University, and Dr. Alan Gregg, Director of the Medical Sciences, Rockefeller Foundation.

Dr. Frank D. Costenbader addressed the Ophthalmological Society of Detroit, Mich., February 27. The title of his address was "Vision in Strabismus." Dr. Costenbader gave the same address before the Washington Ophthalmological Society, March 3, in the Medical Society's building.

Dr. Winfred Overholser addressed a meeting of the Progressive Citizens' Association of Congress Heights, March 10, describing some of the functions of St. Elizabeths Hospital.

Dr. Custis Lee Hall attended the Second Southern Assembly of the United States Chapter of the International College of Surgeons in Tampa, Florida, February 28. Dr. Hall, who is President-elect of the U. S. Chapter, addressed the assembly on the subject, "Treatment of Complications in Fracture Dislocations of Hip."

Dr. Oscar B. Hunter, Director of the Department of Pathology of Doctors Hospital, participated in the program of the Hospital Conference at the Sectional Meeting of the American College of Surgeons, held in Baltimore, March 10 and 11. He discussed the "Stabilization of Medical Staff Organization and Integration of the General Practitioner."

On March 11, **Dr. Brian Blades,** Professor of Surgery, George Washington University School of Medicine, addressed the meeting on "Surgical Treatment of Bronchiectasis."

Dr. William P. Herbst, Professor of Urology at Georgetown University, and Dr. Frank Jones, Clinical Professor of Urology at Howard University, addressed the members of the Medico-Chirurgical Society, Inc. at Howard University School of Medicine, February 27. They discussed problems of venereal diseases.

Dr. Daniel L. Seckinger, Assistant Health Officer, spoke at the quarterly meeting of the Interstate Commission on the Potomac River Basin in Frederick, Md., February 28. Dr. Seckinger is one of the District's three members on the Commission. He emphasized the relation of medical research to stream pollution control and the possibility of "depleted" soil being responsible for nutritional deficiency diseases.

Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, was the speaker, March 3, in the second of a series of four meetings on current international developments, arranged by the Office of Inter-Agency and International Relations of the Federal Security Agency. Dr. Parran, who is the United States' representative to the Interim Commission of the World Health Organization, spoke on "International Health Developments."

Friends of **Comdr. Perry W. Gard, M.C., U.S.N.R.,** will be interested to learn that he returned to active duty with the U. S. Naval Reserve about the first of the year, stating it was his intention to remain with the Navy permanently. He is stationed presently at the U. S. Naval Air Station, Atlanta, Ga.

Dr. John R. Cavanagh announces his reënlistment in the Regular Navy and expects to leave sometime this month for Fort Worth, Texas. He will be commissioned Commander. During the War, Dr. Cavanagh served for four years in the Medical Corps of the Navy.

After serving in the Army for almost two years, **Dr. George Kriegman** was discharged early this year. His address at present is 11 East Franklin Street, Richmond 24, Va.

During a conference on poliomyelitis which was sponsored by the American Red Cross, Eastern Area, in Alexandria, February 25 and 26, **Dr. George C. Ruhland** discussed "Problems in Epidemic Control and Mobilization of Community Facilities for Polio."

Dr. Caroline Jackson, Clinical Instructor in Obstetrics and Gynecology, George Washington University School of Medicine, and Dr. Eleanor Delfs, Associate Professor of Obstetrics and Gynecology, Johns Hopkins University, addressed the Women's Medical Society, March 4, at Doctors Hospital.

Mrs. Walter A. Bloedorn has been appointed Chairman, and **Dr. Brian Blades,** Co-chairman, of an advisory committee to the **Washington Committee for National Civilian Rehabilitation.** Other members of the new advisory committee are Dr. Robert J. Coffey, Dr. Worth B. Daniels, Dr. John H. Lyons, Mrs. Homer Ferguson and Mrs. Carl Spaatz.

Mrs. Bloedorn has been a clinical psychologist at Gallinger Hospital for 20 years.

Added to the list of Society members participating in the programs at **Walter Reed General Hospital** are Dr. Frank J. Eichenlaub, Major Leonard Gilman, and Dr. Hugo V. Rizzoli.

Dr. Edward Larkin has been reappointed to the Executive Committee of the District Chapter of the National Foundation for Infantile Paralysis, Inc., by the Chairman, Judge Fay L. Bentley. Dr. Larkin also was reappointed Chairman of the Medical Advisory Committee.

BOOK REVIEWS

The Second Forty Years. EDWARD J. STIEGLITZ, M.S., M.D., F.A.C.P., with illustrations by Ann Stieglitz. Price, $2.95. Pp. 317. Philadelphia and New York: Lippincott, 1946.

Aging Successfully. GEORGE LAWTON. Price $2.75. Pp. 266. New York: Columbia, 1946.

The appearance of these books is evidence of the growing interest in problems which confront an aging population. These problems are a challenge to physicians as well as to sociologists, economists, public officials, and many others in positions of responsibility.

What can the physician do to extend the useful and healthy life of the older individual? How can the individual himself contribute to his health and well-being with advancing years? Dr. Stieglitz' book seeks to answer these questions. His book is the better of the two which are reviewed here. Written by an eminent medical scientist, this is a very readable and instructive book. Some readers may have hard going with the chapter on biology of senescence. The author himself is cognizant of this fact, but pleads that knowledge of this subject is essential to an understanding of the subsequent chapters.

As for the rest of his book, the average intelligent reader will have little difficulty. He will find it thoroughly fascinating and informative. Of particular interest is Dr. Stieglitz' handling of such subjects as The Hazards of Senescence, The Point of View, Wise Investments of Leisure, and Constructive Medicine.

Written in a more popular vein, Mr. Lawton's book, "Aging Successfully," contains penetrating observations and sound advice to those who approach their latter years with fear and trepidation. Mr. Lawton, a psychologist of long experience, has for many years been a counselor to the aged. Especially helpful to the oldsters are his views on Jobs after Fifty, A Philosophy for Maturity, and Inviting Trouble after Fifty. This book will be widely read because of its readable style and the author's understanding of what motivates human beings.

If the book has any shortcomings, it is that it is "talky." One has the impression that Mr. Lawton writes as he speaks. This has its advantages, but leads to repetition.

Both of these books should be on the library shelves of all those concerned with the well-being of the aging, which includes about all adults in this country.

EDGAR LEONARD GOODMAN, M.D., M.M.S.

(1902–1947)

Dr. Edgar Leonard Goodman, well known ophthalmologist, died unexpectedly, February 28, at his home, 1855 Shepherd Street, N.W. He had practiced his specialty in Washington since 1933, maintaining his office at 1801 Eye Street, N.W. until his death.

Dr. Goodman was a native Washingtonian, born July 4, 1902. After completing his early education at Friends High School, he enrolled at George Washington University, receiving his B. A. degree in 1926 and his degree in medicine in 1929. From 1929 to 1930 he interned at Garfield Hospital, and the following two years he spent in postgraduate study in ophthalmology, serving as resident physician at Wills Eye Hospital, Philadelphia. He received the degree of Master of Medical Science in Ophthalmology from the University of Pennsylvania in 1934.

Since 1933 he had been on the teaching staff of George Washington University School of Medicine, where he held the appointment of Assistant Clinical Professor of Ophthalmology. He was on the associate staff of Episcopal Eye, Ear and Throat, George Washington University and Gallinger Municipal Hospitals, and on the attending staffs of Garfield and Emergency Hospitals.

Dr. Goodman was a diplomate of the American Board of Ophthalmology. He had been an Active member of the Medical Society of the District of Columbia since 1934, a member of the American Medical Association, the Southern Medical Association, the American Academy of Ophthalmology and Otolaryngology, the Washington Ophthalmological Society the Louis Mackall Society, the Washington Medical and Surgical Society, the George Washington University Medical Society, the Faculty Club of George Washington University, and the Wills Hospital Society.

Surviving are his wife, Mrs. Isabel B. Goodman; a son, Charles B. Goodman; his mother, Mrs. Edgar T. Goodman, of Herndon, Va.; and a brother, William C. Goodman, of Washington.

FREDERICK HENRY MORHART, M.D.

(1875–1947)

Dr. Frederick H. Morhart, Washington practitioner for 46 years, died March 5, 1947, in Doctors Hospital after a long illness. He had retired from practice only a year ago.

Dr. Morhart was born in Middleport, Ohio, February 3, 1875. Following his graduation from Columbian University Medical Department in 1898, he became Superintendent of Emergency Hospital. During the Spanish-American War he joined the Army Medical Corps, serving as a Captain in the Philippines. After the War he returned to the District and for a brief period was again Superintendent of Emergency Hospital. During World War I he was stationed in Washington as a Commander in the U. S. Naval Reserve.

For many years he was medical officer of the Potomac Electric Power Company and Capital Transit Company. He was a director of the Liberty National Bank, the Oriental Building and Loan Association, and the Heurich Brewing Company.

Dr. Morhart was a Fellow of the American Medical Association. He became a member of the Medical Association of the District of Columbia in 1899 and of the District Medical Society in 1910. He had been a Life member of the Society since 1940. He was also affiliated with the Military Order of the Carabao, the Association of Oldest Inhabitants, and the Veterans of Foreign Wars.

Surviving are his wife, Mrs. Mamie H. Morhart; a daughter, Mrs. Mari Morhart Hill; and a son, Frederick H. Morhart, Jr., all of Washington. Dr. Morhart resided at 2651 16th Street, N.W.

JAMES RICHARD TUBMAN, M.D.

(1867–1947)

Dr. James Richard Tubman, a Life member of the Medical Society of the District of Columbia, died February 17, 1947, in Doctors Hospital. He resided at 1750 Park Road, N.W.

Dr. Tubman was born in Alexandria, Virginia, March 31, 1867, and received his early education in the District public schools. He attended Gonzaga College, and graduated in medicine from Columbian University Medical Department in 1895.

He was licensed to practice in the District of Columbia the same year.

After engaging in private practice for several years, he became medical examiner of the Peoples Life Insurance Company, which position he held for thirty years before his retirement three years ago.

Dr. Tubman was a member of the American Medical Association. In 1897 he was elected a member of the Medical Association of the District of Columbia and a year later, of the Medical Society of the District of Columbia. His Life membership began January 1, 1938.

His wife, Mrs. Ruth Walton Tubman, survives him together with a brother, Benjamin L. Tubman, and a sister, Miss Ridi Tubman, of Washington.

Pneumonias in Childhood—Rose, Doolan and MacDonald

(*Continued from page 175*)

SUMMARY

In a series of 1,534 cases of pneumonias in childhood studied at Children's Hospital it was found that 1,125 were lobular, 368 lobar, and 51 primary atypical. Up to 2 years of age lobular pneumonia occurred in 64.0 per cent of the cases with a fatality of 13.0 per cent, whereas for the same age group lobar pneumonia occurred in 45.7 per cent with a case fatality of 11.9 per cent. In the age group of 2 years and over lobar pneumonia was present in 54.3 per cent with a case fatality of 1.5 per cent, whereas lobular pneumonia showed an incidence of 36.0 per cent with a case fatality of 2.5 per cent.

In comparing the therapy employed one may conclude that the influence of chemotherapy has been striking. The course of the disease has been shortened as evidenced by the duration of the febrile period and length of stay in the hospital. The mortality rate and the incidence of complications, notably empyema, have been decidedly reduced. It is somewhat disappointing when averages are considered to find patients receiving penicillin therapy lacking in spectacular response.

BIBLIOGRAPHY

1. Rose, J. (Washington, D. C.), Schapiro, M. M., and McLarney, E. P.: Survey of childhood pneumonias. M. Ann. District of Columbia, 1938, **7**, 44.
2. Ross, S., Burke, F. G., and McLendon, P. A.: Penicillin by mouth; report of clinical trial. J. A. M. A., 1945, **129**, 327.

Diathermy Machines—Stephens

(*Continued from page 182*)

with their local communities by making sure that their machines meet the F.C.C. regulations.

5. The full effect of enforcement of these regulations by the F.C.C. will probably be felt within two years.

6. It is suggested that, prior to purchase, a written statement be obtained to the effect that a machine does meet the F.C.C. regulations, the exact extent thereof, and how the machine will be marked with this information.

7. It is important that service be available in order that if the machine should begin to operate outside its approved limits, the cause may be remedied without delay.

The writer wishes to express his appreciation to Dr. E. G. Lipow for his review and suggestions and to the Federal Communications Commission for their kindly assistance and comments.

Footnotes—Observer

(*Continued from page 207*)

anything about the mice for obvious reasons. It seems that the mice were flown to and from the tests by the Navy, although they belonged to the National Cancer Institute. The Army, too, got its hand in, just how no one knows. At any rate, Dr. Lorenz could not talk because of what the reporter described as "red tape" which would reach from Washington to Moscow. All the reporter wanted to know was "if the mice had had any babies since their horrible experience at Bikini."

T. W.

New George Washington Hospital

(*Continued from page 216*)

ufacturing rooms, as well as fully equipped dispensary.

Dental Department. An additional service with two complete dental surgical units for inpatient and outpatient care.

Membership

(*Continued from page 219*)

Joseph J. McCarthy, Jr., Georgetown University—1942
Jasper Wayne McFarland, College of Medical Evengelists—1939
Henry Joseph Myers, Tufts Medical School—1941
Royal Reynolds, University of Pennsylvania—1906
Frederick W. Schneider, Georgetown University—1943
Norman Taub, University of Chicago—1941
Jean J. Vivino, University of Minnesota—1944
Ferdinand Welebir, College of Medical Evangelists—1936

For Associate Membership

Albert Emanuel Long, University of Virginia—1935

Recent changes in membership status:

Active to Associate

Perry W. Gard
Edward J. Grass
John C. Sherburne

Resigned
Active

Austin B. Chim
William S. Derrick
William A. Withers

Washington Physicians of Yesterday—Wilmer

(*Continued from page 212*)

In 1925 he reluctantly left Washington to create and direct the Wilmer Ophthalmological Institute of Johns Hopkins Hospital in Baltimore, established by patients and friends and named for him. He served in this capacity, and also as Professor of Ophthalmology at Johns Hopkins University and Ophthalmologist-in-Chief of Johns Hopkins Hospital, until his retirement in 1934. He then returned to and resumed practice in Washington until his death in 1936.

He made contributions to medical literature, including a book, "Fundus Oculi," published in 1934. A number of his younger office associates became prominent ophthalmological practitioners in Washington.

He married Re Lewis Smith October 8, 1891, and left three children.

Wilmer the scientist was built on Wilmer the man. In personality and character Dr. Wilmer was friendly, kindly, unassuming; gentlemanly, cultured, honorable. No adventitious circumstances contributed to his success; it was through sheer force of personal ability and character that he won his great reputation and practice. He was a man of broad culture and varied interests. He was fond of hunting, and a fine shot; and in his early days he was something of an equestrian and athlete. He was a connoisseur in etchings. On his country estate he engaged enthusiastically in tree culture; and he was president of the American Horticultural Society. He was a member of the Society of the Cincinnati, and president of its New Jersey State Society.

Dr. Wilmer died suddenly, March 12, 1936. His remains rest in the National Cathedral in Washington.

JOHN B. NICHOLS, M.D.

MEDICAL ANNALS
of the
DISTRICT OF COLUMBIA

VOLUME XVI *May, 1947* NUMBER 5

THE PROPERTIES AND CLINICAL APPLICATIONS OF STREPTOMYCIN THERAPY*

JOHN A. KOLMER, M.D., F.A.C.P.
Professor of Medicine, Temple University; Director of Research Institute of Cutaneous Medicine, Philadelphia

A NOTEWORTHY advance in antibiotic therapy was made in 1944 by Schatz, Bugie and Waksman in the discovery of streptomycin which is produced in fluid cultures of Streptomyces griseus (Actinomyces griseus), a microörganism isolated by Waksman in 1919 from the soil. This agent was so named because Streptomyces griseus belongs to a group of Actinomycetes having the generic name Streptomyces.

In general terms, the properties of streptomycin are strikingly similar to those of penicillin except that the former is far more active against gram-negative and acid-fast bacilli, which renders it a compound of hopeful therapeutic value in the treatment of diseases due to the enteric bacilli as well as to the Brucella, H. influenzae, Klebsiella pneumoniae, Pasteurella tularensis and the tubercle bacillus. At the present time the full therapeutic possibilities of streptomycin have not been determined, but the compound has been successfully employed in the treatment of a sufficient number of experimental infections of the lower animals, and in various diseases of man, to clearly indicate that it is a compound of proven therapeutic value.

After drying, streptomycin is assayed for potency by the Oxford cup method which is expressed in terms of weight equivalent to streptomycin base. Each lot is also tested for (a) sterility, (b) moisture content, (c) pyrogenic substances, (d) the presence of histamine-like impurities, (e) streptothricin, and (f) the clarity of solutions. It is particularly important that it should not contain an excess of histamine-like impurities so largely responsible for some of the toxic reactions.

UNIT

The original unit was the smallest amount of streptomycin inhibiting the growth of a suitable culture of Escherichia coli in 1 c.c. of broth medium.

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* Presented before the 17th Annual Scientific Assembly of the Society, October 1, 1946, with extended remarks on the pharmacology and therapeutic applications of streptomycin made before the George Washington University Medical Society on October 19, 1946.

The official unit adopted by the Division of Medical Sciences of the National Research Council is the smallest amount equal to 1 microgram (0.001 mg.) of streptomycin base which is equivalent to 1 original unit. On this basis the dosage of streptomycin is now expressed in terms of weight instead of units in which 0.010 Gm. equals 10,000 units; 0.1 Gm., 100,000 units; 0.5 Gm., 500,000 units; and 1.0 Gm., 1,000,000 units. The compound (sulfate or hydrochloride salts) is now dispensed in containers containing 1.0 Gm.

ANTIMICROBIAL ACTIVITY

As previously stated, streptomycin is particularly active against certain gram-negative bacilli in vitro, as shown in table 1. It also possesses some activity against such gram-positive organisms as staphylococci, streptococci, pneumococci, and especially tubercle bacilli, but is relatively ineffective against the Clostridia of gaseous gangrene and cellulitis.

TABLE 1
Antimicrobial Activity

HIGHLY EFFECTIVE	MODERATELY EFFECTIVE	SLIGHTLY EFFECTIVE	RELATIVELY INEFFECTIVE
Past. tularensis*	Ps. pyocyanea*	B. mallei*	Cl. welchii†
Kleb. pneumoniae*	The Salmonella*	V. cholerae*	Cl. septicum†
H. influenzae*	Br. abortus*	Gonococci*	Cl. butyricum†
H. pertussis*	Br. melitensis*	Meningococci*	T. pallidum
Esch. coli*	Br. suis*	A. bovis†	Rickettsiae
Aerobacter aerogenes*	Eber. typhi*	Staphylococci†	Viruses
Proteus vulgaris*		Streptococci†	Yeasts and molds
Shig. dysenteriae*		Pneumococci†	Protozoa
B. anthracis†		C. diphtheriae†	
B. subtilis†			
Myco. tuberculosis†			

* Gram-negative
† Gram-positive

MECHANISM OF ANTIBACTERIAL ACTIVITY

The exact mechanism of the antimicrobial activity of penicillin and streptomycin in vitro and in vivo is not known at the present time.

Both compounds are most active against young proliferating bacterial cells. Consequently, they are more effective in the treatment of acute than of chronic infections.

Their activity appears to depend upon interfering with cellular division which prevents the multiplication of bacterial cells (genesistasis) with the frequent production of pleomorphic changes. Crippled organisms in vivo are then thought to be largely removed by phagocytosis and particularly by the cells of the lymphoid-reticulo-endothelial system.

VALUE OF ACCURATE BACTERIOLOGIC DIAGNOSIS

Whenever possible, accurate bacteriologic examinations are always necessary or advisable in relation to penicillin and streptomycin therapy, since the administration of these compounds is indicated only in the treatment of those diseases due to susceptible organisms. For example, streptomycin is the compound of choice in the treatment of diseases due to gram-negative bacilli and tubercle bacilli.

They are also indicated when mixed infections are suspected, as in lung abscess, empyema, bronchiectasis, sinusitis, chronic wounds, etc., since mixed treatment with penicillin and streptomycin may be indicated.

In many instances, however, the physician or surgeon is justified in making a presumptive diagnosis on the basis of the signs and symptoms presented and proceeding with penicillin or streptomycin therapy without further delay. Indeed, in many of the severe infections like the septicemias, suppurative meningitides, pneumonias, acute osteomyelitis, etc., treatment should be instituted as soon as possible since it can be stopped, with no harm done, if bacteriologic examinations subsequently show that the case is unsuitable for penicillin or streptomycin therapy.

The Use of Inactivators in Blood Cultures

When blood cultures are made in cases under penicillin therapy it is always advisable to add a substance to the broth medium capable of inactivating the compound in the blood in order to prevent falsely negative cultures. Clarase in dose of 0.01 Gm. per 100 c.c. medium may be employed, but 5 to 10 units of penicillinase (Schering Corporation) per 100 c.c. is preferred. Cysteine hydrochloride may be bactericidal and should not be employed.

In blood cultures of cases under streptomycin therapy it is advisable to add 5 c.c. of a sterile 1:300 solution of hydroxylamine hydrochloride, which has been adjusted to pH 6.0 with sodium hydroxide, to 100 c.c. of the medium for the inactivation of the compound.

Natural Resistance of Bacteria

Different cultures of any bacterium susceptible to penicillin may possess a high natural resistance to the compound. Thus, streptococci of the viridans type and anaerobic streptococci are much more resistant than hemolytic streptococci of group A; staphylococci also vary a good deal in susceptibility. The same is true of streptomycin. Thus, some strains of Escherichia coli, Proteus, Ps. pyocyanea, staphylococci, etc., may be much more resistant than usual. This has an important bearing upon the dosage of these compounds and may be responsible for therapeutic failures.

Sometimes streptococci, staphylococci and other gram-positive organisms may be found more susceptible to streptomycin than to penicillin in vitro, with the suggestion that streptomycin may be preferred in treatment.

Acquired Resistance of Bacteria

Bacteria susceptible to penicillin and streptomycin may acquire resistance to the compounds during treatment which also has an important bearing upon dosage and methods of treatment. Bacteria acquire resistance to streptomycin much more rapidly and frequently than to penicillin. Consequently, the compounds should not be used indiscriminately in the treatment of disease.

Acquired resistance, however, may not actually occur but only represent the survival of naturally resistant variants. In other words, the compounds may rapidly eliminate highly susceptible organisms and leave more resistant variants which are thought to be organisms that have acquired resistance.

Susceptibility of Sulfonamide-Resistant Bacteria

Fortunately, gonococci, pneumococci, streptococci, staphylococci and other penicillin-susceptible organisms possessing a natural or acquired resistance to the sulfonamide compounds are highly susceptible to penicillin both in vitro and in vivo. Consequently, cases resistant to sulfonamide therapy are amenable to treatment with the compound.

Likewise, streptococci, staphylococci, penumococci and other organisms with acquired or natural resistance to penicillin may be susceptible to streptomycin, and the reverse.

Importance of Susceptibility Tests

Consequently, the laboratory is frequently requested to determine the susceptibility of bacteria to penicillin and streptomycin in vitro as a clinical guide to dosage and administration. Infections due to strains with high natural or acquired resistance require larger dosage and more prolonged treatment than highly susceptible strains.

The susceptibility tests of Kolmer, and of Levine and associates, are simple and satisfactory. The paper disc method of Bondi and his associates, however, is particularly satisfactory for making routine bacteriologic diagnosis and determining susceptibility to both penicillin and streptomycin simultaneously within 24 to 48 hours; briefly, the method is as follows:

(1) Streak the material being examined on each of 2 blood agar plates; (2) on each plate place a sterile disc of filter paper (6.5 mm.) moistened with a solution of penicillin (15 units per c.c.) and a second disc moistened with a solution of streptomycin (500 units per c.c.); (3) incubate 1 plate aerobically and the second anaerobically for 24 to 48 hours; (4) examine colonies for identification of bacteria present; examine for zones of inhibition of growth around the respective discs and measure each in mm.; (5) the absence of zones indicates resistance. The larger the zones of inhibition the greater the susceptibility of the organism or organisms to penicillin and streptomycin respectively.

METHODS OF ADMINISTRATION

Streptomycin, like penicillin, is highly soluble in water, saline and glucose solutions. It is rapidly absorbed after intramuscular and subcutaneous injection but poorly or not at all after oral administration; it apparently diffuses in the body like penicillin. Streptomycin is also rapidly excreted by the kidneys and liver but probably not as rapidly as penicillin. Consequently, the methods of administration are similar to those employed in penicillin therapy as follows:

1. Orally only for the preoperative or other indications for reduction of intestinal bacteria.
2. Intravenously (intermittently or continuously) only in very severe infections.
3. Intramedullary injections permissible in infants and children.
4. Intramuscular injections every 3 to 4 hours preferred and usually sufficient; in peanut oil and beeswax not as satisfactory as penicillin.
5. Subcutaneous injections every 3 to 4 hours permissible and well borne.
6. Intrathecal injections once daily in the treatment of suppurative meningitis in dose of 0.025–0.05 Gm.
7. Intrathoracic injections once daily in the treatment of empyema in dose of 0.05–0.1 Gm.
8. Intraäbdominal injections once daily in the treatment of generalized peritonitis in dose of 0.05–0.1 Gm.
9. Intratracheal instillations once daily in dose of 0.01 to 0.05 Gm. in 3–5 c.c. saline solution, in the treatment of certain respiratory tract infections.
10. Aerosols daily, in dose of 0.025 and 0.05 Gm. per c.c. saline solution, in the treatment of certain respiratory tract infections.

Renal blockade by the oral administration of sodium benzoate for raising and prolonging blood levels of the compound are apparently not as satisfactory as with penicillin.

DOSAGE

The doses of streptomycin to employ in the

TABLE 2

*Dosage by Intramuscular Administration**

DISEASE	DAILY (GM.)	TOTAL (DAYS)	AVERAGE TOTAL (GM.)
Urinary Tract	1.0–3.0	5–10	5.0–30.0
Tularemia	0.5–1.0	5–7	3.0– 7.0
Septicemia	2.0–4.0	5–10	10.0–40.0
Meningitis†	0.5–1.0	5–8	3.0– 8.0
Typhoid Fever	3.0–5.0	10–14	30.0–70.0
Brucellosis	4.0–5.0	10–14	40.0–70.0
Peritonitis‡	2.0–4.0	5–10	10.0–40.0
Salmonella infections	3.0–5.0	10–14	30.0–70.0
Cholangitis	2.0–4.0	5–10	10.0–40.0

* Suggested by Committee on Chemotherapeutics and Other Agents

† Supplemented by daily intrathecal injections of 0.025–0.05 Gm.

‡ Supplemented by daily intraäbdominal injections of 0.05–0.1 Gm.

treatment of infections due to susceptible organisms are not yet defined, but those indicated in the treatment of a number of diseases according to present data and experience are shown in table 2, as suggested by the Committee on Chemotherapeutics and Other Agents. In view of the fact that streptomycin costs about $10.00 per gram, it is apparent that streptomycin therapy is apt to be quite costly. It is likely, however, that its cost will become progressively reduced as production and demand increase, and especially when it is found possible to produce the compound synthetically.

Toxicity

Undoubtedly streptomycin is somewhat more toxic than penicillin, but toxicity has been progressively reduced by improved methods of production, resulting in the elimination of impurities. The usual untoward or toxic reactions observed with compounds now being employed may be summarized as follows:

1. Local: Irritation; tingling; paresthesia. Phlebitis due to intravenous injections.
2. Histamine-like: Flushing and headache sometimes with nausea and vomiting.
3. Skin rashes: Urticarial; erythematous; maculopapular and sometimes hemorrhagic. Apparently due to allergic sensitization.
4. Fever: due to sensitization or to pyrogenic substances.
5. Neurologic: Vertigo due to labyrinthine disturbances usually occurring upon prolonged treatment and likely to be irreversible; tinnitus and deafness occurring in the treatment of tuberculous meningitis and typhoid fever and thought to be due to disease.
6. Sometimes arthralgia; occasionally albuminuria. No effects upon the bone marrow. No disturbances of kidney and renal function.

Assays of the Blood and Other Body Fluids

Assays of the serum, spinal fluid, urine and other body fluids are always advisable in relation to streptomycin therapy.

Effective concentrations in the serum probably vary from about 2 to 20 micrograms (units) per c.c. or higher, according to the nature of the infection. In general terms, dosage should be such as to maintain a concentration in the blood 4 to 8 times higher than found necessary for bacteriostatic effects in vitro.

The cup method of Stebbins and Robinson, using the SM strain of Staphylococcus aureus, the serial dilution method of Price and his associates, using Bacterium circulans, or the Fleming slide method using Bacterium megatherium, may be employed.

Synergistic Activity

Streptomycin and penicillin may be administered together by intramuscular injection for additive or synergistic effects and especially in the treatment of mixed infections with gram-negative and gram-positive organisms.

It is also advisable to administer the sulfonamide compounds along with streptomycin in the treatment of severe infections with gram-negative bacilli as in the suppurative meningitides, septicemias, acute endocarditis, etc.

Since combined treatment of experimental tuberculosis of guinea pigs with streptomycin, promin and diasone has proven more effective than streptomycin alone, it appears that such combined treatment is worthy of trial in the treatment of tuberculosis of man.

Causes of Treatment Failure

Among possible causes for failure in streptomycin therapy may be mentioned: (a) infections due to organisms possessing high natural or acquired resistance; (b) doses too small or duration of treatment too brief; (c) overwhelmingly severe infections; (d) localization of infections in areas inaccessible to streptomycin; (e) inadequate surgical drainage, and (f) occurrence of superinfections due to other organisms.

Principles of Treatment

The important principles of streptomycin therapy are essentially the same as in penicillin therapy and may be briefly summarized as follows: (a) accurate bacteriologic diagnosis whenever possible as a basis for treatment; (b) tests for susceptibility of organisms as a basis for dosage; (c) serum assays at intervals as a basis for dosage and route of administration; (d) institution of treatment as soon as possible; (e) in acute infections large doses over a short period of time, instead of small doses over a long period; (f) not to regard streptomycin therapy as a substitute for adequate surgical measures, and (g) to use sulfonamides, penicillin, immune sera, blood transfusions, etc., if and when required for additive or synergistic effects.

Therapeutic Effectiveness

The effectiveness of streptomycin in the treatment of disease has not yet been fully determined, but in table 3 I have attempted to list those diseases and infections in which the compound may be regarded as effective, helpful, questionable or ineffective, according to present information and experience.

Especially good therapeutic results have been observed in the treatment of tularemia. Excellent results have also been observed in the treatment of urinary tract infections due to gram-negative bacilli, although streptomycin therapy is not a substitute for adequate surgery in the obstructive uropathies, aside from the problem of acquired resistance of organisms and the frequency of relapsing infections upon the cessation of treatment. Undoubtedly streptomycin is also the compound of choice in the treatment of all septicemias due to gram-negative bacilli, and especially those secondary to urinary tract infections. It has also proven of value in the treatment of the suppurative meningitides and brain abscesses due to Hemophilus influenzae, Klebsiella pneumoniae, Escherichia coli and other gram-negative bacilli. Furthermore, it has proven the most hopeful compound available at present in the treatment of tuberculous meningitis with the complete bacteriologic and clinical recovery of at least 2 cases up to the present time. Streptomycin has also proven effective in the treatment of the pneumonias and suppurative pneumonitides due to Hemophilus influenzae, Klebsiella pneumoniae, Proteus, Ps.

(Continued on page 285)

TABLE 3

Therapeutic Effectiveness

EFFECTIVE	HELPFUL	QUESTIONABLE	INEFFECTIVE
Cystitis*	Abscess of liver*	Brucellosis, chronic	Amebic hepatitis
Empyema*	Bronchiectasis*	Tuberculous meningitis	Gangrene
Laryngotracheitis*	Brucellosis, acute	Typhoid fever	Fungus infections
Meningitis*	Burns*		Infectious mononucleosis
Osteomyelitis*	Cholangitis*		Malaria
Pneumonitis*	Dysentery, bacillary		Ozena
Pyelitis*	Endocarditis, acute*		Rheumatoid arthritis
Pyelonephritis*	Infections of the skin*		Syphilis
Septicemia*	Lung abscess*		Typhus fever
Tularemia	Otitis media*		Ulcerative colitis
	Peritonitis*		Virus infections
	Salmonella infections		
	Tuberculosis		
	Wounds*		

* Due to infections with gram-negative bacilli.

DIABETES MELLITUS IN CHILDREN*†

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We have heard the statement made that the treatment of a diabetic child is essentially the same as that of an adult. In some respects this is true. However, the factors concerned with the growth and development, the integration of the various endocrine glands, and behavior problems make the life of the juvenile diabetic a rather unique one.

These remarks are based on a survey of the records of 32 male and 40 female juvenile diabetics treated by members of our group. In addition we have had the opportunity to examine most of the diabetic children who have been treated at the Children's Hospital, Washington, D. C., during the past 25 years. The opinions given here are based on this experience.

Diagnosis

The diagnosis of diabetes mellitus in the child is not ordinarily a difficult one to make. Because the disease is rather rare in patients under 15 years of age, one must have diabetes in his mind when seeing a patient. Too often a child will have to consult 2 physicians because a urinalysis will not have been made by the first examiner. In our experience the dextrose tolerance test, which has been of great value to us in the diagnosis of adult diabetes, has not been used very frequently in diagnosing diabetes in the child. Its chief value in the young patient is to eliminate the non-diabetic. The finding of dextrose in the urine, elevated blood sugars, both fasting and after meals, together with certain observations and symptoms which can be elicited, will usually make the diagnosis a rather easy one. The most common initial findings and symptoms in the order of their appearance are loss of weight, polyuria, polydipsia, enuresis, coma or acidosis, anorexia and fatigue.

Heredity

Heredity plays an important part in the development of diabetes, and becomes more and more apparent as the patient grows older and relatives develop the disease or show evidence of endocrine disorders, particularly those involving the thyroid gland.

Growth and Development

Diabetes follows a rather benign course in children prior to puberty and is rather easily controlled by diet and rather small doses of insulin. During the period of greatest sexual development a radical change in the character of the disease takes place, the disease changing from mild or moderately severe to severe. This is noted earliest in girls. The insulin requirements mount rapidly and the dietary needs increase at a rate sufficient to support growth and essential physical activity. The increased activity of the pituitary, thyroid and adrenal glands tends to partially neutralize the effect of exogenous and endogenous insulin. The mental attitude of the patient changes from one who accepts authority to a person who does his or her own reasoning, and who not infrequently modifies the planned

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* From the Children's and the Garfield Memorial Hospitals.

† Presented October 28, 1946, as part of Course No. 6 on Internal Medicine, sponsored by the American College of Physicians at Gallinger Municipal Hospital, October 21–November 1, 1946.

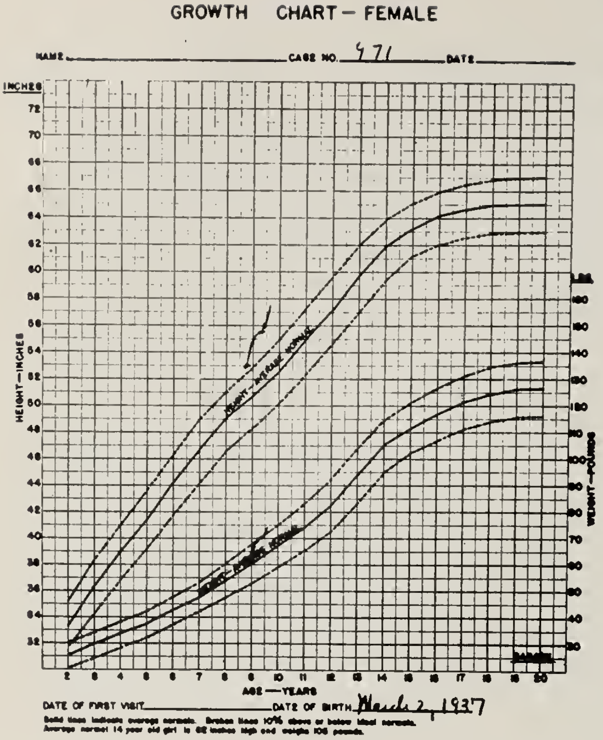

Fig. 1. Rapid increase of 4.5 inches in height during the year following the onset of diabetes.

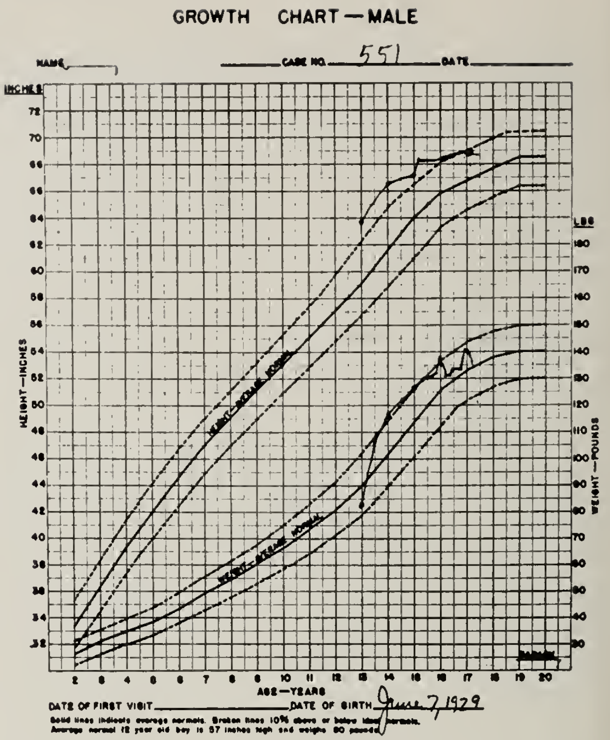

Fig. 2. Rapid gain of 35 pounds during first year of treatment, normal weight being attained.

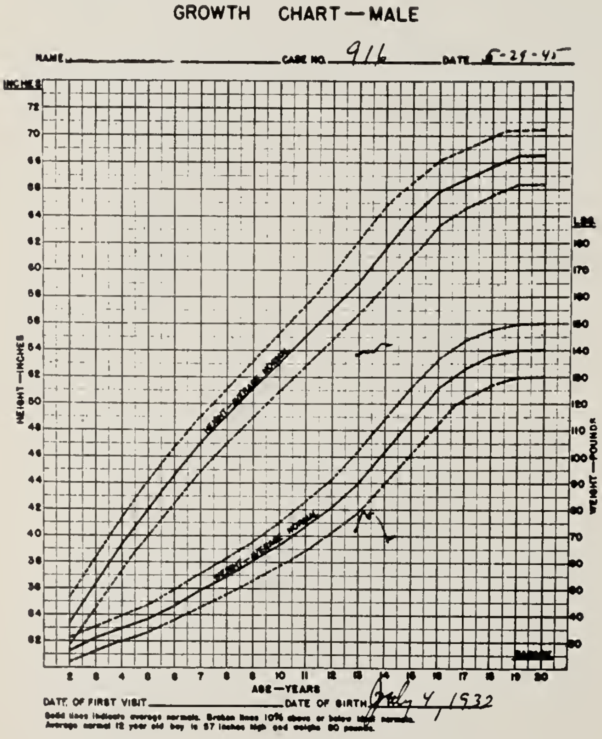

Fig. 3. Diabetic dwarf. Height and weight have remained essentially unchanged during period of 1.5 years. Marked fluctuation of blood sugars, frequent periods of acidosis.

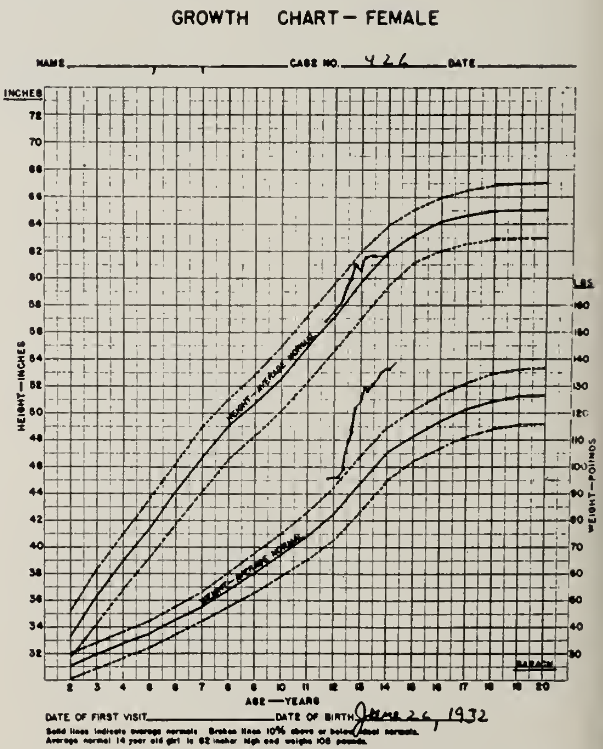

Fig. 4. Uncontrolled dietary intake with gain of 43 pounds in 2 years. 100 units insulin daily.

treatment of the physician and will at times refuse to follow the desires of his parents. After the twentieth year, the disease becomes less severe and is usually more easily controlled from that time on.

Growth and development of most diabetic children proceed normally. However, approximately 12 per cent of our patients were taller than normal, and 13 per cent were underheight, with a tendency to be overweight in 7 per cent. Undernourishment was almost nonexistent after treatment had been well established. A number of children experience a rapid period of growth just prior to the recognition of their diabetes. Menarche most frequently occurred in our patients during the fifteenth year, approximately 1 year later than in nondiabetics. The following height-weight charts, as devised by Dr. Joseph H. Barach, demonstrate some of the variations in height and weight as seen in children with diabetes (figures 1, 2, 3 and 4).

DIET

Before discussing the matter of diet and insulin we would like to emphasize the desirability of having a patient enter the hospital for a period of approximately 2 weeks for the initial regulation of his diabetes. The proper estimation of the diet and the determination of the insulin dosage require this, if the disease is to be properly treated and the parents impressed with the plan of treatment and adequately instructed.

The diabetic diet is based on the requirements of the individual. Up to the tenth year, boys and girls receive approximately the same diet, but from this age on the needs of the male exceed those of the female (chart 1). In general we follow the plan of White,[1] which provides 1,000 calories at 1 year of age and adds 100 calories for each year after that. The total requirements for girls rarely exceed 2,200 calories. The amount of carbohydrate is determined by taking 10 per cent of the total calories of the diet and using this figure as grams. The ratio of carbohydrate, protein and fat is 2.0 : 0.9 : 1.0 (chart 2). For a boy of 10 years, the total number of calories would be 2,000, with carbohydrate 200 grams, protein 80–90 grams and fat 100 grams. Such a diet would be divided into 3 main meals, with midafternoon and bedtime feedings. Sometimes a midmorning meal may be given. The amount of carbohydrate is usually less at breakfast than at lunch and dinner. The bedtime feeding, which formerly consisted of approximately 10 grams of carbohydrate as fruit juice, may at times be replaced by one containing protein and fat to give a more prolonged absorption of food. Milk or a small sandwich are satisfactory for this purpose. The quantity of carbohydrate taken between meals usually amounts to 10 grams. When globin insulin is given, midafternoon carbohydrate nourishment should be

CHART 1

Diet at Various Age Levels

AGE (YEARS)	MALE				FEMALE			
	Carbohydrate	Protein	Fat	Calories	Carbohydrate	Protein	Fat	Calories
3	112	43	58	1142	118	72	67	1362
5	130	57	77	1441	140	65	79	1531
10	167	72	100	1856	187	71	95	1887
15	230	95	124	2416	147	74	89	1685
20	190	100	120	2240	161	81	92	1796

CHART 2

Estimation of Dietary Requirements

(Pricilla White[1])

At age of 1 year allow 1,000 calories.
Add 100 calories for each year of age.
Do not exceed 2,200 calories for girls.
Carbohydrate: 10 per cent of total calories are given as grams of carbohydrate

Ratio of C–P–F:	
Carbohydrate	2.0
Fat	1.0
Protein	0.9

Example: 10-year-old boy

Calories	2,000	
Carbohydrate	200 × 4 =	800
Protein	90 × 4 =	360
Fat	100 × 9 =	900
		2,060 calories

provided, but a bedtime feeding may not be necessary.

Diets necessarily have to be individualized, and formulae such as have been given merely serve as guides and are not to be rigidly followed. Many children will need less than this rule provides for, others considerably more. On days when a child is more active than others, Saturdays and Sundays, he may require more food. Strenuous exercise means additional food, either during or after the period of activity. When discharging a young diabetic from the hospital, it is usually desirable to increase his diet and reduce his insulin.

INSULIN

Although diet represents the keystone of treatment, all diabetic children require the use of insulin. Proper development and life are impossible without it. The most satisfactory method of giving insulin in our experience has been to supply between two thirds and three quarters of the total insulin requirements as protamine zinc insulin, supplementing the balance with crystalline or regular insulin, usually given at breakfast time with an occasional dose of the latter at supper. Children of 2 or 3 years of age can sometimes get along on protamine zinc insulin alone; however, this is the exception rather than the rule. If globin insulin is given, an injection is usually administered 30 to 60 minutes before breakfast, the balance at suppertime or later. Occasionally 1 dose given in the morning will be sufficient.

Two out of 22 patients using mixtures of protamine zinc and unmodified insulin or modified protamine zinc insulin N P 50 * were put back on separate doses of the 2 insulins because of unsatisfactory results. Two out of 8 children who were given globin insulin had this insulin discontinued because of similar difficulties.

The amount of insulin required per day during the first 5 years of life averages between 10 and 20 units, but following this there is a rather rapid increase for girls, reaching the peak between the sixteenth and twentieth years (figure 5). The rise in the requirements for the males does not take place to any degree until the ninth or tenth year.

During periods of the greatest need for insulin the average daily requirement is approximately 70 units, but amounts as high as 117 units have been given.

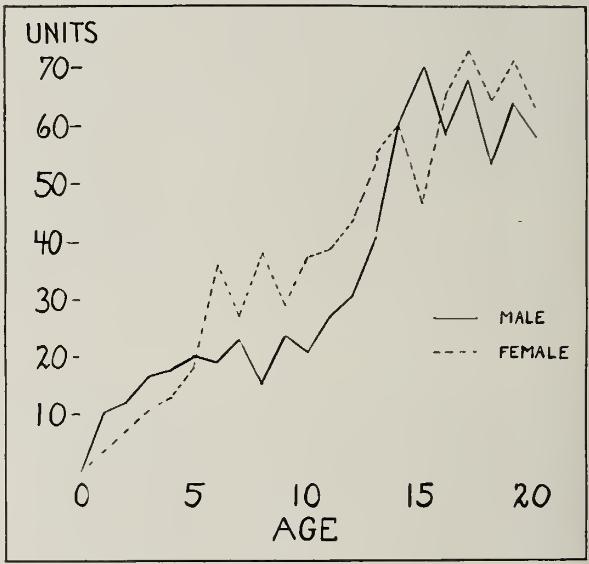

FIG. 5. Insulin at various ages.

Insulin reactions vary in frequency and severity in different children. Most mothers soon learn to recognize the symptoms and signs of an insulin reaction and take appropriate means to combat them. Sometimes it will be desirable to give the insulin after breakfast rather than before, since some children will awaken with a low blood sugar and show signs of an insulin reaction after the injection has been given and before the breakfast has been eaten. Although a patient who is very sensitive to insulin will in all likelihood have reactions with all types of insulin, it will sometimes be found that changing from protamine zinc and unmodified insulin to globin will give better results.

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* Supplied by Eli Lilly and Company, Indianapolis, Indiana.

COMA

Coma or severe acidosis is not infrequently seen at the time of the recognition of the disease, and some patients in the lower social-economic levels will be repeated offenders. Our private patients have rarely gone into coma after treatment has been well established. To our knowledge but 2 of our juvenile patients have died of diabetic coma, 1 of these having run away from home, the other not coöperating because of mental retardation. Deaths from diabetic coma, although needless, are seen when the patient is brought to the hospital in extremis, or if the admitting physician fails to make the proper diagnosis, or if the patient fails to receive prompt and adequate treatment after the diagnosis is made. Infection is often the inciting factor in the metabolic upset.

The treatment of coma is essentially the same as in the adult except for the proportionately smaller amounts of fluid and insulin given. Insulin early and in adequate dosage is of prime importance. In general a child between 1 and 5 years of age will require between 25 and 100 units of insulin to combat his coma. Older children will usually require between 75 and 300 or more units to restore their acid-base equilibrium. It has been our practice not to use dextrose during the first part of coma treatment until a significant drop in blood sugar indicates the utilization of this sugar. Carbohydrate is then given intravenously and later by mouth.

Fluids used have been physiologic salt solution, lactate-Ringer, and one-sixth molar lactate solutions. Gastric lavage has been routinely given, leaving some sodium bicarbonate solution and a dose of castor oil in the stomach before withdrawing the tube.

PSYCHOLOGIC PROBLEMS

Most physicians will find that although diet and insulin are the most important factors in the treatment of the diabetic child, these alone will not solve his difficulties in the continued care of his patients over the years. One really treats 2 persons when caring for a diabetic child, viz., mother and child. To inspire a desire on the part of the child to coöperate, and to be able to have both parent and patient acquire some appreciation of the reasons for treatment, should be the aims of the physician. It is surprising how much knowledge of diabetes a young girl or boy can attain. If a spirit of comradeship between doctor and child can be obtained more than half of the battle will have been won. Efforts should be made to accommodate the diet to the patient's needs rather than fitting the patient to the diet. Ice cream can be substituted for a 20 per cent fruit. Occasionally and by way of variety a soft drink can be taken in place of the usual mid-afternoon feeding if that is what the companions of the patient are taking. One should never sympathize with diabetic boys or girls over the fact that they have diabetes, because they will adjust themselves to the prescribed regimen. They should be taught to take care of themselves and encouraged to mix with their fellows, their activities being curtailed only when not to do so would unfavorably affect their diabetic control.

Diabetic camps have been of great help to patient, parent and physician in enabling the child to lead a normal life. Such an organization also aids the parents to obtain a welcome vacation.

The greatest difficulties in the treatment of the juvenile diabetic will come with those from broken homes. Where there has been a divorce or separation of the parents, when both parents are employed, or if adequate discipline has not been established, difficulty in obtaining satisfactory coöperation and proper diabetic control will almost surely follow. Constant nagging regarding diet, etc., by members of the family will not help in obtaining coöperation from the child. Finally the physician should have a real desire to treat diabetes and should endeavor to keep abreast of advances.

Many mothers acquire a surprising skill and knowledge of the treatment of the disease, so that the doctor must maintain a sufficient interest to keep her confidence. This can be obtained in part by the physician keeping the mother informed of the various findings such as blood sugar estimations, readjustment of diet and insulin, providing for visits to his office, the submission of reports on the patient's condition, urinalysis, etc., by mail and telephone, and keeping her advised of any new developments in diabetic therapy or knowledge.

FUTURE OF THE JUVENILE DIABETIC

One of the most stimulating aspects of the care of the young diabetic is the realization that both patient and doctor are blazing a trail over which but few have trod. The days when we waxed enthusiastic over our 10-year juvenile diabetics have long since passed, and we are approaching the time when some of our young patients are about to attain 30 years of living with their disease. What we find in these young men and women will be of great value to others, since they may point the way to the better treatment of those who follow them. Already we see evidences of arteriosclerosis, retinopathies, toxemias of pregnancy, neuroses, and other conditions which are peculiar to these young diabetics. We have learned that the sexual development of these young women is different from their nondiabetic sisters, viz., that a women 25 years of age whose diabetes is of 10 years' duration has an ovarian age 5 to 10 years beyond her chronologic age.[2]

To have contributed to the freeing of a child from the doom of the pre-insulin era and to have helped him or her to live almost as long as the nondiabetic, and actually competing with them, mean that the physician who conscientiously treats the juvenile diabetic is bound to receive the most satisfactory rewards possible, the gratitude of the parents of such a patient and the saving and maintenance of a life for useful service. Such are the things which make the practice of medicine worth while.

BIBLIOGRAPHY

1. JOSLIN, E. P., ROOT, H. F., WHITE, P., AND MARBLE, A.: The Treatment of Diabetes Mellitus, 7th ed. Philadelphia: Lea, 1940, p. 674.
2. WHITE, P.: Proc. Am. Diabetes A., to be published.

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RHEUMATIC FEVER: CURRENT CONSIDERATIONS*†

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THE observation that rheumatic fever as a clinical entity appears to be undergoing modifications with the passage of time has probably been made with increasing frequency during the past decade; some most recent testimony has appeared in the English medical literature. Dr. J. A. Glover[1] feels that this disease ("juvenile rheumatism") is constantly declining in incidence and (as also may be the case with scarlet fever) generally in its manifestations is becoming less severe. Other detailed descriptions[2, 3, 4] of a "benign type" or of "acute febrile polyarthritis" suggest that an outstanding characteristic of this "new disease" or "new type of rheumatic fever" is the absence of carditis.

In Rochester, New York, Dr. A. D. Kaiser[5] has been describing developments probably of like character as the occurrence of a "clinical syndrome in children resembling rheumatic fever." This milder disease or milder form of the disease is quite similar in symptomatology and epidemiology to traditional rheumatic fever, carditis excepted. Age, urbanization, poverty, familial incidence, and tendency to recur are common epidemiologic factors, and differences in throat flora and cutaneous hypersensitivity with respect to the hemolytic streptococcus appear to be quantitative only.

It does not appear that a conclusive interpretation of these observations can be made at the present time. If rheumatic fever, by definition, is to be considered a hemolytic streptococcal disease, it is possible that the majority of cases which have been described in this connection should be regarded as representing variants of the latter as a disease entity.

In any event, although change in the character of the disease may be suspected, recent, comparatively rapidly developing knowledge of events in the course of rheumatic fever in its definite and well recognized forms necessitates further revision of our conception of its natural history. Only a very few years ago, in many quarters no continuity of process whatever was realized between the traditional triad of "tonsillitis, chorea, and arthritis," and the only genuinely inimical feature recognized; namely, the remotely associated, curiously developing cardiac decompensation arising "purely upon the basis of physical deformity of valve leaflets" (sic). Appreciation of the pathologic and clinical events during the often continuous course of the characteristically chronic disease affecting many more tissues of the body has followed. Recognition and appropriate evaluation of the continuous or recurrent toxic and inflammatory processes involving the heart (upon which rigid physical valvular deformity may indeed be consequent) have been the basis upon which a most formidable "rest regimen" has gradually evolved as the standard practice of treatment, probably because no genuinely effective therapeutic measures have been available.

With the identification of characteristic antecedent infections, obviously of importance in pathogenesis, difficulties of interpretation have arisen. Recent investigations bearing upon these points are numerous. One of the current year, however, may illustrate the necessity for continued revision of conceptions of the general pattern of the disease. Rantz, Boisvert and Spink,[6] during a field study of the Army Commission on Hemolytic Streptococcal Infections, were apparently able to take advantage of the recent aggregation of patients in military camps in the study of 1,500 of them in various types of acute infections, among whom 15 cases of definite and typical rheumatic fever developed. Very briefly, conclusions drawn from these observations were that consequent upon acute hemolytic streptococcus infection several types of disease process may eventuate:

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* Read at a meeting of the Medical and Chirurgical Faculty of the State of Maryland, October 10, 1946.

† From the National Institute of Health (Division of Infectious Diseases), Bethesda, Md.

1. A continuing "disease process"; unidentified illness with recovery, characterized by fatigability, increased erythrocyte sedimentation rate, and fever.
2. An essentially similar process but with electrocardiographically demonstrable evidence of associated cardiac inflammation.
3. Superficially, genuine rheumatic fever, characterized by migrating polyarthritis, fever, and rapid sedimentation rate, but without demonstrable evidence of carditis.
4. Definite rheumatic fever with carditis but without attendant arthritis.
5. Characteristic rheumatic fever with arthritis and carditis.

Finally, and most pertinent to our present discussion (to dispense, perhaps unwarrantedly, with many qualifying details), the observations indicated that the conception of a "latent period" between the so-called "antecedent infection" and the disease (rheumatic fever) hitherto considered "subsequent" is untenable. Close observation demonstrated that fever, increased sedimentation rate, rapid pulse, anorexia, and fatigue usually continued without remission after subsidence of local inflammation (in the throat, for instance) and that this disease process merged with the subsequently developing arthritis and carditis.

This further and not unanticipated bridging of the gap between initial bacterial infection of apparently banal type and the manifestations of active carditis is probably to be accepted as an example of the continuous amplification of our knowledge concerning the natural history of rheumatic fever.

The authors (Rantz, Boisvert and Spink[6]) logically observe, with reference to the five types of resulting disease enumerated: "Carditis with and carditis without arthritis must be regarded as comparable disorders, and both appear to be related to arthritic disease without carditis. Since arthritis has been demonstrated without carditis and carditis has been demonstrated without arthritis, there appears to be no valid reason for concluding that examples of continuing disease in the absence of both these clinical phenomena are unrelated to the first type of disorder."

These and similar considerations have, of course, given occasion for the employment of such terms as "post streptococcic state," or "streptococcosis," "streptococcic fever," or "rheumatic fever syndrome," and the like.

The well recognized nosologic dilemma to which such analysis leads was lucidly outlined by Dr. J. R. Paul: "So much for the close relationship between rheumatic fever and streptococcus infections in which it is granted that much is unknown. Until more is known, some of us who have been interested in rheumatic fever as a clinical entity believe that it would be a mistake to discard wholly the concept of rheumatic fever as a disease per se, any more than we should discard scarlet fever. How can one determine its prevalence, for instance, unless its individuality is upheld?"[7]

During the past 7 or 8 years reports of a number of interesting demonstrations, valuable to students of the etiology of rheumatic fever, of the protective effect of small daily doses of sulfonamide (frequently, 1.0 gram of sulfanilamide) for those children most likely susceptible to relapses of this characteristically recurrent disease, have on the whole indicated that under close supervision such procedure can safely be employed to decisively reduce the incidence of relapses in rheumatic fever patients.[8]

Although the possibility of inducing hypersensitivity to the medicament employed by continuous administration for periods up to 8 years (as recommended) is not infrequently mentioned, it would appear that even more to be apprehended is unfavorable alteration in the state of immunologic reactivity between the patient and the infectious processes to which he may be subject. There has been a most convincing demonstration[9] of the pathogenetic effects of such medication given during the course of pneumonia and concurrently with therapeutic serum. Löfgren[10] has emphasized the decisive influence of the exhibition of such compounds, especially sulfathiazole, in engendering the extensive development of erythema nodosum lesions in tuberculous and hemolytic streptococcus-infected individuals. The exceedingly untoward effects of medication of this type in active rheumatic fever are, of course, well recognized.

The intravenous administration of sodium salicylate in the treatment of rheumatic fever, introduced by Ontaneda and Molina in 1934,[11] and more recently a practice, usually of temporary vogue, in some medical communities in this country, enabled administration in doses even more heroic than those ventured for such purpose in the era of initial trial and experiment with drugs of this type (antipyretics). Such practice, fortunately only transiently resurgent, served a good purpose in recalling to attention the considerable value of aminopyrene as an antipyretic, when one is indicated, for patients with cardiac decompensation of advanced degree.[12] Through the use of this drug,[13] with proper observance of precautions to detect possibly incipient leukopenia (especially in the early stages of medication), advantage safely may be taken of the fact that only small doses are usually required, gastric irritation minimized or avoided and increase of sodium intake incident to medication obviated if this is considered advantageous to counteract fluid accumulation.

About a year ago Gubner and Szucs [14] reported the use of a mixture, apparently of a "calcium benzoate with succinic acid benzyl ester" in conjunction with ascorbic acid, as an antipyretic in rheumatic fever. Since the mixture is one of relatively low toxicity and possesses definite, although relatively weak, antipyretic properties in benzoic acid, while succinic acid is demonstrably effective in promoting several essential enzyme reactions characteristically inhibited in rheumatic fever or by salicylates, theoretically, the mixture should possess merit. This, however, did not appear to be attested convincingly by the report describing its use in the treatment of about 50 rheumatic fever patients in comparison with a similar number of controls receiving sodium salicylate, although a marked superiority of the mixture was suggested in the comparative incidence tabulated of carditis, number of relapses, duration of illness, and the like.

At present the consensus of conversant medical men is probably that rest constitutes the sole fundamentally effective therapeutic measure available. Actual proof of the soundness of this widely accepted conclusion, or demonstrations of even a relative effectiveness, however, do not appear to be available in the medical literature. On the other hand, common clinical experience frequently suggests that the course of the disease and the evolution of cardiac lesions may not be demonstrably influenced either by rigidly enforced rest or the indulgence in unrestricted physical activity.

Although suspecting that the "rest cure" as generally managed may on the whole be actually detrimental in its effect, there is a natural disinclination, in the absence of substantiating evidence, to contravene almost universally established practice. A few somewhat cautious increases in liberality in this respect have been reported, as for instance, upon the application of "fitness tests" in a military physical fitness laboratory in Texas.[15] The average reconditioning time for convalescent rheumatic fever patients was thereby reduced from 77 days to 16 without prejudice and with apparent benefit to the individual.

Furthermore, a preliminary report in June 1946[16] describes an even greater departure from established practice, with apparent attendant benefit: During the entire course of hospitalization for rheumatic fever the comfort of the patient alone was the deciding factor in determining the amount of exertion undertaken in each case. It would seem that this might prove a most liberal criterion indeed, but details of the records of the 200 patients under observation describe its modification only in instances of congestive heart failure. The authors point out that "rest" and "confinement" are by no means synonymous. Activities were permitted at the inclination of each individual patient during the acute phase of the disease, and it is stated that rarely did joint discomfort interdict ambulatory activity for more than 48 hours.

A marked decrease in anxiety neuroses was chief of the many favorable results described. Patients slept soundly, and the energy expended in tossing in bed was minimized. It is impossible to convey briefly an adequate conception of the magnitude of general improvement which apparently resulted. One individual, for instance, ambulatory at desire during the appearance of crops of subcutaneous nodules and the invariably attendant intense rheumatic activity, recovered from the attack and was discharged after 37 weeks with a "grade 2" apical systolic murmur as the only recognizable evidence of cardiac damage and with no indication of decreased cardiac reserve. The authors state that since the inauguration of the methods outlined in 1944 no cause for regret at the change has arisen.

SUMMARY

1. Observations on this continent and in Europe continue to suggest that: (a) Rheumatic fever is gradually becoming a milder affliction, or (b) that patients in increasing numbers present a new but superficially similar disease, generally milder, especially with respect to carditis.

2. There is increasing appreciation of events during the "silent period" between the so-called "antecedent infection" and the "onset of rheumatic fever." These and related observations enjoin consideration of the suggestion that rheumatic fever can most appropriately be regarded (among several manifestations only quantitatively distinct) as a condition representative of the "post-streptococcic state."

3. Although it is probable that physical rest is widely considered the fundamental, potentially effective, therapeutic measure, recent observations suggest that relatively greater benefit on the whole may be obtained in most patients if at least a moderate degree of physical activity is allowed.

BIBLIOGRAPHY

1. Glover, J. A.: Lancet, 1943, **2,** 51.
2. Copeman, W. S. C.: Ann. Rheumat. Dis., 1944, **4,** 11.
3. Ackerman, W. L.: Ibid., 1945, **5,** 14.
4. Ferguson, G. C.: Canad. M. A. J., 1943, **49,** 492.
5. Kaiser, A. D.: New York State J. Med., 1943, **43,** 1937.
6. Rantz, H. H., Boisvert, P. J., and Spink, W. W.· Arch. Int. Med., 1945, **76,** 131.
7. Paul, J. R.: Rhode Island M. J., 1945, **28,** 15.
8. Cumulative Statistical Review: M. Clin. North America May 1946.
9. Rich, A. R.: Bull. Johns Hopkins Hosp., 1942, **71,** 123.
10. Löfgren, S.: Acta med. Scandinav., 1945, **122,** 175.
11. Ontaneda, L. E., and Molina, M. A.: Revist. Sanidad Militar (Argent.), 1935, **34,** 3.
12. Manchester, R. C.: J. A. M. A., 1946, **131,** 209.
13. Schultz, M. P.: Arch. Int. Med., 1931, **48,** 1138.
14. Gubner, R., and Szucs, M.: New England J. Med., 1945, **233,** 652.
15. Karpovich, P. V., and others: J. A. M. A., 1946, **130,** 1198.
16. Robertson, H. F., Schmidt, R. E., and Feiring, W.: Am. J. M. Sc., 1946, **211,** 67.

MODERN PSYCHIATRY IN GENERAL PRACTICE

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Modern psychiatry offers useful concepts for the general practitioner to aid his diagnostic and therapeutic acumen. It is possible for him to learn to practice the kind of medicine the psychoneurotic patient needs. By learning to use modern concepts of psychiatry physicians help themselves and get some idea of what comprehensive medicine means, because physicians too may be neurotic. The physician can understand and help the patient to the degree he can understand and help himself. This is not learned in school or from the usual experiences in living. It is only by specific efforts in this direction, involving the development of awareness in interpersonal relations, that the individual can achieve maturity, or self-reliance through self-understanding. Such physicians are needed not only because of the increased demand for psychiatric services, but as leaders in modern medicine, since maturity itself is an achievement.

Increased understanding gives the doctor a feeling of the dynamic qualities and the human value of the doctor-patient relationship. He is introduced to broad patterns of human motivation and to the common causes and backgrounds of emotional disturbance and illness. He learns the more easily understandable methods of therapy in order that he can treat a share of such illness, and he learns to recognize the more malignant conditions to be referred for more comprehensive treatment.

Any individual who consults a physician manifests some degree of insecurity. It is of utmost importance that the physician take adequate cognizance of this condition. Too often all emphasis is placed on the physical symptoms alone. The individual, however, presents attitudes or mental symptoms in addition to the physical symptoms. It is these symptoms which are the subject of this discussion. The nervous patient should not just be labeled "neurotic," as a distinct entity, but considered a total personality with all that the concept implies.

Attitudes at any given moment are the result of life experiences to that moment. They are acquired, not inherited, and therefore can be changed or removed. This is analogous to efforts to change or remove physical symptoms. All of us are born potentially compassionate and creative, but later events, such as undue frustration, may alter these tendencies. The infant has obvious physical needs, and when these are met the body develops properly. There are less obvious mental or emotional needs, and when these are met the attitudes develop properly. The most basic of these needs is security, or freedom from fear and worry. This is acquired early from the most significant people in the environment, usually the mother, through perception of attitude. However, sensitivity to the attitudes of others is always present throughout life. We are all more or less controlled by group pressures, which is perception of attitude multiplied many times.

The degree of security acquired determines the degree of maturity that can be developed through experiences that make for maturity. This emotional maturity does not come chronologically as physical maturity usually does. All difficulties in living can be expressed in terms of emotional immaturity demonstrated in interpersonal relations. There are occasions when it is desirable to act emotionally as, e.g., when listening to music. There are many occasions when it is better to act rationally, as, e.g., when confronted with decisions in living. It is to the degree that the individual functions emotionally when he should function rationally that he functions immaturely. Maturity involves self-reliance, ability to accept responsibility, and awareness of motivation.

People are aware of communicating verbally but are less aware of an older form of communication, dating from early infancy. This is a form of empathy or perception of attitude. Undue anxiety demonstrated by the physician and even out of his awareness is communicated to the patient and adds to his already existing anxiety. Self-assurance is assuring to the patient only when it is real. The physician also has usually latent feelings about what the patient is saying. This is conveyed to the patient although the physician may not realize this, and he may be at a loss to understand the patient's reactions to him.

Overemotionality is frequently present but may not appear consciously in the individual except in the form of anxiety. Most people will concede lack of awareness for motivation when questioned concerning specific behavior patterns. This leads to a propensity to indulge in rationalizations. This is a form of self-deception through justification, or finding excuses for what is done. Also difficulties are frequently experienced through inability to take a categorical attitude when the individual lacks self-confidence, or self-assurance. The conflict arises when the individual must choose between what he wants to do and what he ought to do. The usual efforts to acquire self-confidence involve efforts in the direction of some successful accomplishment, or proving oneself, but this is never adequate. Self-assurance can only be achieved through self-understanding. It is easier for the individual to be sure when he knows "why."

The individual reflects toward others the attitude which he really has toward himself. When he does not have self-respect, he cannot adequately respect others. This, however, arouses a subconscious and occasionally conscious feeling of guilt, or he experiences a troubled conscience. This in turn is usually translated into too much need for the respect of others, in which situation there is limited ability for self-respect and eventual frustration and hostility, as, e.g., "I need you. You don't respond to my need. Therefore, I hate you." Thus dependence makes for frustration, and frustration makes for hostility. This hostility, which the patient cannot consciously accept, often causes physical symptoms. Emotions such as fear or anxiety that exist only unconsciously produce tension, local or general, as, e.g., migraine or possibly essential hypertension. All will agree that this tension can be more exhausting than physical exertion. The individuals actually use the symptoms in an effort to avoid experiencing basic emotions but inevitably develop secondary emotions.

There has been increasing interest in so-called "psychosomatic medicine," in which it is contended that physical symptoms have emotional causes. It is, however, implied that, although there is a relation between mind and body, there is also a definite difference. There is reason to doubt this. Even the layman recognizes that acute emotional experiences such as fear or rage are reflected in the pulse, blood pressure, etc. "Psychosomatic medicine" further implies that the failure of the individual to adjust to his environment is expressed in physical symptoms.

In pediatrics, feeding, excretory problems, and allergies are common examples of psychogenic complaints in children. It is pertinent to mention at this time that illness in children is always accompanied by anxiety, which also must be treated, including that anxiety reflected from the mother. The mother should always be present when the child is given an anesthetic, and when the child awakens. Oversolicitude is a form of concealed hostility most frequently inflicted by the parent on the child. The parent has a latent tendency to reject the child and compensates for this by chronic anxiety for the child's welfare. The child's attitude can be changed when the parents change their attitude toward the child. Relatively little change in the parents is amplified when reflected by the child. Children have natural tendencies and these come into conflict with cultural standards as revealed by the parent. Life at its best is extremely frustrating to the child. Children learn more by imitation than by verbal instruction. It therefore behooves the parents to set the proper example. This makes for a minimum of discipline. Children often use symptoms as an escape, as an attention-gaining mechanism, or to avoid anxiety. It is an important factor in diagnosis and in convalescence to be able to size up the family-child relations. Youngest children have to contend with older siblings as well as the parents. An only child also has obvious problems that are revealed when he becomes a medical problem. The rapid healing and recovery of children make for even more satisfaction of successful accomplishment when there is a personal in addition to a professional relationship involved.

Surgery and medicine offer many opportunities for psychosomatic understanding. For example, peptic ulcer is called "sergeant's disease" in the British army. This type of complaint has been much more frequent in the recent conflict as compared with the hysterias and exhaustion symptoms in the First World War. Recognition of the effect of attitudes on the presenting symptoms calls for caution in the use of medication. Attitudes cannot be significantly influenced by medication or physiotherapy. Such symptomatic therapy is indicated when it is recognized as only a means to an end, and to relieve secondary anxiety arising from the symptoms. The factors of concealed emotions make for tension in both smooth and striated muscle, often localized. This may present itself as some form of myositis, or even arthritis or gastritis or colitis. When the etiologic factors are found to be psychogenic, comprehensive psychotherapy, usually beyond the ability of the practitioner, is indicated. The gratitude of the patient is adequate compensation for referring the case. There is little doubt that essential hypertension involves emotional difficulties in living and may significantly contribute to arteriosclerosis. Asthmatics, eczemas and other forms of allergy have emotional components that predispose to, as well as result from, the symptomatology.

Sex problems including promiscuity, impotence or frigidity are usually psychogenic and cannot be relieved by medication (including hormones) or any form of surgery. Sex behavior is symptomatic, not casual. The individual's attitude toward sex is an index of his attitude toward other problems of living. When the couple concerned with sexual maladjustment learn to get along well out of bed, they will adjust in bed. Sexual maturity can only be achieved through maturity in other ways of living.

Finally, in the field of geriatrics, psychosomatic understanding is especially helpful. As the individual ages, difficulty is experienced in utilizing usual forms of escape, and he is more alone. This difficulty arises because being alone forces the individual to face himself. This situation gives rise to tension symptoms or anxiety. Although the aged are less flexible, they are never inflexible.

In conclusion and summary, it is contended that individuals experience general and local tensions, emotional in origin, and engendered by difficulties arising from interpersonal relations in the environment. These tensions are frequently experienced in the form of physical symptoms that can simulate any form of disease. Understanding the influence of the emotions is necessary to convey the understanding to the patient. It isn't enough to tell the patient that his symptoms are mental, since this conveys the idea that he is only imagining he is sick and evokes anger or discouragement. It is necessary to give the patient adequate opportunity to talk, since this often enables him to see his irrationality and thus to see things differently.

(*Continued on page 285*)

CLINICO-PATHOLOGIC CONFERENCE*

Georgetown University Medical Division of Gallinger Municipal Hospital

Conducted by
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Dr. Jeghers: The differential diagnosis of the following case history will be given by Dr. Bernard Nunez, our guest discusser for today.

Case History

This patient, a 65-year-old Egyptian female, was admitted to a fever hospital in Cairo, Egypt on May 1, 1945. She was a native of Cairo.

Present Illness: Fifteen days prior to admission the patient had a chill followed by a remittent fever of 104° to 106°F. which lasted for 5 days. It terminated abruptly with much sweating. During the febrile period there was intense pain in the back and extremities, prostration, arthralgia, severe headache, and some nausea and vomiting. An afebrile period lasting 3 days followed, during which all the symptoms abated. On the ninth day another chill occurred followed by a febrile episode lasting several days. This was accompanied by severe prostration, headache, dizziness, pains in the joints and abdomen, vomiting and finally coma.

Physical Examination: The clothing was full of body lice. On examination the patient was in a comatose condition. She was fairly well developed and well nourished, but dehydrated and icteric. The corneal reflex was absent. The tongue was dry. There were petechiae and a macular rash over the neck, trunk, and in the inner side of the extremities. There was herpes on the lips. Respirations were of the Cheyne-Stokes type. Examination of the chest was negative. The heart sounds were muffled, and the heart showed sinus arrhythmia. The spleen was palpable 2 fingerbreadths below the costal margin. The liver was palpated 1 fingerbreadth below the right costal margin. The remainder of the physical examination was negative. The pulse rate was 130. The blood pressure was 80 mm. Hg systolic and 60 mm. Hg diastolic.

Laboratory Findings: Repeated blood smears for malaria parasites were negative. Blood cultures were all negative. The white blood cell count was 17,800, with predominant polymorphonuclear leukocytes. The urine showed a slight trace of albumin and was highly concentrated. The blood nonprotein nitrogen was 42 mg. per cent.

Clinical Course: The patient remained in a comatose state. A lumbar puncture showed clear fluid under increased tension, which was relieved by removing 10 c.c. of the clear fluid. The heart sounds became very weak and slow. Glucose and saline solutions were administered intravenously. The patient died on May 3, 2 days after admission and without regaining consciousness.

Clinical Discussion

Dr. Bernard Nunez: In the first place, I will take for granted that all have read the protocol of the case. Since the patient was an Egyptian woman, I assumed when I read the history that the diagnosis would be schistosomiasis, but apparently that is not true.

We have to consider that the patient was 65; probably this is important. She was seen in Cairo. I know that the American Typhus Commission had a ward there, but I don't think they worked this case up. Since Cairo is in the same latitude as Washington, the season was spring.

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* This Conference was held at 12:00 Noon, Friday, December 20, 1946, in the Medical Auditorium of Gallinger Municipal Hospital for members of the third-year class.

Fifteen days before admission the patient had a chill and then developed a fever which lasted for 5 days and fell by crisis. On the ninth day she developed another bout of fever for several days. Therefore, this was a relapsing type of fever. We will have to consider the diseases which cause a fever of this type. The main ones are relapsing fever, which may be tick- or louse-borne and is caused by Borrelia recurrentis and Borrelia duttoni, sandfly fever, dengue, yellow fever, trench fever, rat-bite fever, and of course malaria.

In this case the afebrile period lasted 3 days. This is unusual except for relapsing fever. During this time all symptoms abated. Then on the ninth day another chill occurred followed by fever accompanied by severe prostration, headache, dizziness, pains in the joints and abdomen, vomiting and finally coma. The only significant symptom was dizziness which is prominent in relapsing fever, typhus, and malaria due to involvement of the vestibular apparatus. Headache might be expected in any of the diseases I mentioned. Joint pain is characteristic of spirochetal, virus, and rickettsial diseases. Usually it is a periarticular pain. For example, in typhus or dengue the patient may complain of pain in the joints, although they look normal and can be moved passively without pain. Probably in this case the pain was periarticular.

Physical examination showed body lice, a not unusual state in Egypt. This finding is put in a prominent place in the protocol. Should we bite? We will look on it with concern, since relapsing fever, typhus, and trench fever are transmitted by the louse. If this is an important finding the diagnosis is easy, but I don't know.

The development of coma in relapsing fever is rare. The relapses usually get milder as they go on. In this case the finding of coma is against a diagnosis of relapsing fever unless there was some complication like meningitis or pneumonia. As a matter of fact, death from uncomplicated relapsing fever is uncommon; usually there is a complication such as endocarditis, meningitis, or pneumonia. The patient was well developed and well nourished. This helps to point out that there was no preëxisting disease. She was dehydrated and icteric. The dehydration may have been due to fever and lack of attention. The icterus is very significant. It is seen in relapsing fever due to parenchymatous fatty infiltration of the liver and to invasion of the reticuloendothelial system and edema and cloudy swelling of the cells. The corneal reflex was absent. This finding is not too significant in a patient in coma. The absence of this reflex is an early sign in basilar meningitis. The most significant thing was the rash, which was petechial and macular over the neck, trunk, and in the inner sides of the extremities. This description fits perfectly the rash of relapsing fever. In this disease the rash is present in the first bout but can be seen also in the relapses. In typhus the rash appears about 4 to 7 days from the onset. These two diseases are sometimes seen together. Both are transmitted by a louse. The incubation period of relapsing fever is shorter, and the patient may be ill for a time, improve temporarily, and then go on to die of typhus. In sandfly fever the rash is not prominent and is seldom petechial. In dengue the rash resembles measles and is not petechial. The same is true in trench fever and rat-bite fever. Any kind of rash is rare in malaria except urticaria. The herpes on the lips is not too significant; it is common in fever from any cause. The respirations were of the Cheyne-Stokes type. This is easy to explain in view of the increased intracranial pressure and probable anoxemia due to the low pulse pressure. The chest was negative, but this means little. It is difficult to be sure that there is no pulmonary disease in a patient in coma. The heart sounds were muffled and there was sinus arrhythmia.

We would like to know if the arrythmia was of the nonphasic type. If so, it would be more important. The spleen was palpable 2 fingerbreadths below the costal margin. Enlargement of the spleen is seen in relapsing fever, dengue, trench fever, and malaria. The liver was palpated 1 fingerbreadth below the costal margin. This finding is common in relapsing fever. The pulse was 130, the blood pressure 80/60. It is well to consider here the possibility of hemorrhage or adrenal disturbance of some type other than the Waterhouse-Friderichsen syndrome which is usually seen in young patients with meningitis, but some similar lesion in the adrenal. In typhus low blood pressure, rapid pulse, and azotemia are common in severe cases. The studies of the American Typhus Commission showed that death never occurs in typhus with a normal blood nonprotein nitrogen. However, these findings might be part of the picture of any overwhelming infection.

Repeated blood smears for malaria parasites were negative. The significance of this finding depends on the care with which the examinations were made. The smears are rarely negative in acute malaria. If we trust the report, this finding is therefore significant. Blood cultures were negative. Meningitis as a complication of relapsing fever is a diagnostic consideration. The fact that the blood cultures were negative is against this diagnosis; usually there is meningococcemia. The white blood cell count of 17,800 with predominant polys may be another red herring. Elevation of the white count is not seen in typhus. On the other hand, the count may be high in relapsing fever. The urine findings are not exciting. In typhus renal lesions are reported. Usually the azotemia is prerenal, however. Albuminuria is seen in any fever. The blood nonprotein nitrogen is slightly high; information as to when this test was made might help in ruling out typhus.

The patient remained in coma. The lumbar puncture showed clear fluid under increased tension. This is against the idea of meningitis as a complication of relapsing fever, although the fluid may remain clear in appearance for many hours. The cell count of the fluid is not mentioned. The heart sounds became weak and slow. The bradycardia may have been due to the icterus or to the increase in intracranial pressure, especially if the latter developed suddenly. The spirochetes of relapsing fever invade the brain, causing cellular infiltration and even plugging of capillaries.

We have no indication that agglutination tests or smears for spirochetes were made. Nevertheless, my diagnosis is relapsing fever. I believe that the patient developed a complication in the relapse, either typhus or meningitis.

DR. HAROLD JEGHERS: Does anyone in the audience care to comment further on this case? If not, may we hear what diagnoses were handed in by the members of the third-year class?

DR. PAUL JAQUET: Seventy-five diagnoses were submitted. Fifty-five were of relapsing fever; 13 of typhus fever; 2 of rat-bite fever; 1 of recurrent fever; 2 of yellow fever; 1 of sarcoidosis, and 1 of septicemia.

DR. HAROLD JEGHERS: It appears that the majority of the class have the same opinion as to the nature of the disease in this case as does Dr. Nunez.

Dr. Geschickter will now present the pathologic findings found at the postmortem examination.

DR. GESCHICKTER: Dr. Nunez was correct as regards the main diagnosis. The anatomic diagnoses were (1) relapsing fever with hemorrhage into the skin, spleen, peritoneal cavity, and wall of bowel and congestion of the pia-arachnoid; (2) arteriosclerosis (grade 2) of aorta, heart, kidney and brain; (3) ulcerative vaginitis and cervicitis; (4) hypostatic bronchopneumonia; (5) infarction and hemorrhage of the spleen which was enlarged; (6) hepatitis of moderate degree; (7) schistosomiasis of the bladder and gastrointestinal mucosa; (8) advanced pyelonephritis; (9) hyperplasia of the lymph nodes

(10) focal encephalitis; and (11) nonspecific dermatitis.

Schistosomiasis in this case was an incidental finding and not the cause of death. Microscopic lesions were noted in the bladder, gastrointestinal tract, and lung. Localization in the urinary bladder is common in Egyptians. Carcinoma of the bladder frequently occurs as a complication. Schistosomiasis in Egypt is a common cause of hematuria.

There is but little doubt that relapsing fever was the main cause of death in this patient. It was probably louse-borne. The patient's age and the long period before treatment was commenced undoubtedly contributed to her death. There was no evidence of typhus fever or bacterial meningitis as a terminal complication, but bronchopneumonia did develop.

At postmortem examination in a typical case of relapsing fever the most characteristic and constant pathologic changes are in the spleen, which is enlarged, soft, and with multiple areas of infarction; in addition, miliary abscess-like lesions are visible grossly which are composed of histiocytes and plasma cells with only rare leukocytes. By means of appropriate stains masses of Borrelia can be seen collected around the periphery of these miliary abscesses. The liver may be enlarged and present parenchymatous degeneration. Visceral surfaces of most organs usually show areas of hemorrhage and may be bile-stained. A major associated finding, and often the contributing cause of death, is a complicating pneumonia.

DR. HAROLD JEGHERS: Relapsing fever occurs over most of the world except in Australia. In Africa it is the third commonest major infectious disease, ranking next to malaria and sleeping sickness (trypanosomiasis). In the United States the tick-borne type of relapsing fever is endemic in 13 or more states (Washington, Oregon, California, Montana, Idaho, Nevada, Arizona, Utah, Colorado, New Mexico, Kansas, Oklahoma and Texas) and is by no means rare. For example, 258 cases were reported in Texas from 1930 to 1934. During the Nineteenth Century epidemics of louse-borne relapsing fever occasionally occurred in Eastern seaport cities, but except for a rare sporadic case it is no longer encountered. An indication of the current importance of this disease in the United States was the publication in 1942 of a 130-page book which contained the material from a symposium on relapsing fever presented on December 30–31, 1941 at Dallas, Texas, at a meeting of the American Association for the Advancement of Science under the auspices of the Section on Medical Sciences.

Although the case under discussion today was seen in Egypt, the problem is one with which American physicians should be familiar, particularly if they practice in the American endemic states. It is well to remember that modern travel permits a person to arrive in Washington, D.C. from any American or foreign endemic area well within the usual incubation period of 7 days. The possibility of encountering a case in this locality is therefore a real but remote one.

Relapsing fever is due to a spirochete (Borrelia) organism and may be louse-borne or tick-borne.

The human louse, Pediculus humanus, is the vector of the louse-borne type and causes the disease when crushed on the skin, an act which allows the spirochetes, Borrelia recurrentis, present in the hemocele fluid of the louse to enter the body through a wound, scratch or bite mark. The disease is not caused by the louse bite or from its feces. Man is the reservoir host, and the disease is conveyed from person to person by the louse. This type of relapsing fever may be epidemic in time of overcrowding and poverty.

Various ticks of the genus ornithodorus are the vectors of the tick-borne type of relapsing fever. Wild animals are the reservoir host. The disease is transmitted congenitally from tick to tick. Ticks can infect humans within 1 hour after attaching themselves by a mechanism that is not entirely clear. The tick form of the disease due to the Borrelia duttoni is sporadic and endemic and tends to be milder, with a case fatality rate much lower than the louse-borne type.

The tick-borne cases of relapsing fever in the United States are characterized by an abrupt onset with a sharp rise in the temperature to 104°F., often with a chill, with muscle and joint aches, headache, back pain, and a varying degree of prostration. Occasionally, various respiratory signs and symptoms have been noted. The increase in the heart rate is in proportion to the fever. Leukocytosis is the rule. The Wassermann and Kahn tests may be temporarily positive. A rash of rose spots or petechiae may occur. The liver and especially the spleen may be palpable. Vomiting occurs at times. Jaundice is present in severe cases and is apparently due to liver damage. Fever is well sustained for 2 to 5 days and then terminates suddenly by a crisis with profuse drenching sweats. Relapses occur at intervals of 2 to 9 days, 1 or more times. Between relapses the patient is afebrile and feels much improved. Mortality of the American cases has been very low. Elsewhere in the world it varies from 5 to 50 per cent, being more severe in the louse-borne type and in debilitated persons.

The characteristic relapsing temperature curve (defined as febrile peaks usually with sharp rise and fall and of variable duration with 1 or more intervening afebrile days) is the best clue to diagnosis. In this country such a febrile course occurs primarily in malaria, rat-bite fever, relapsing fever, chronic meningococcemia, and Colorado tick fever. As a rule the temperature curve of dengue is "saddle-back" rather than relapsing, but the latter type may occasionally occur. True relasing type of fever curve should not be confused with the Pel-Ebstein fever of Hodgkin's disease, the undulant fever of brucellosis, the hectic or septic type of quotidian intermittent fever, and the secondary temperature rise of many common infectious diseases when a complication occurs. Certain diseases, like typhoid or Weil's disease, may have a true relapse of the disease with a febrile response, but the temperature curve is different from the type under discussion.

Another helpful diagnostic point would be the history of a previous tick bite or exposure to ticks in a person ill with a febrile disease. The Borrelia organisms may be demonstrated in the blood during a febrile episode either on a blood smear from the patient or by inoculating a mouse with the patient's blood. After one or two days the organisms may be demonstrated in the mouse's blood or in properly stained sections of the spleen or brain.

Arsphenamines and penicillin are effective remedies, espcecially when used early in a febrile relapse. It is claimed that treatment should be avoided if a natural crisis is near, since a shock-like state may result.

Muscular asthenia and facial paralysis were the more serious sequelae noted in recovered persons in this country.

Relapsing fever, artificially produced, has been used in place of malaria in the treatment of neurologic complications of syphilis.

President's Page

AMA CENTENNIAL

THE AMERICAN MEDICAL ASSOCIATION will celebrate its 100th birthday when it meets at Atlantic City in June. This Centennial Session will undoubtedly be one of the finest medical meetings of our time. For the great strides which have marked the progress of medicine in the past century will be the subject of discussion by eminent scientists from all parts of the world. It promises, therefore, to be a never-to-be-forgotten occasion and every medical man who can possibly do so should be present.

There will, of course, be other meetings besides those of a scientific nature. For example. the accomplishments of the AMA in the social and economic field will be reviewed. Despite unfortunate incidents in recent years which created the impression that the Association was opposed to any change whatsoever in medical practice, it has many outstanding accomplishments to its credit. These, too, will come in for considerable discussion. It will be interesting to hear what our colleagues from overseas have to say on this controversial subject.

Let me suggest to our members who attend the AMA's Centennial meeting that they not confine themselves entirely to scientific sessions, but that they look in on the sessions of the House of Delegates. A surprise is in store for those who have not done so before. I can assure them that if they will listen attentively, they will have a much better understanding of organized medicine than they have had heretofore. Fellows of the AMA are welcome to attend meetings of the House and, in my opinion, they should take advantage of it.

It is my sincere hope that every physician who can possibly do so will be present at least on one day during the Atlantic City meeting. Washington physicians are particularly fortunate in being so close to the place where the meeting is held. Attendance from Washington should, therefore, be excellent.

William P Herbst Jr

Editorials

THE FIRST AND FUNDAMENTAL STEP*

The shibboleth of medical organizations today seems to be public relations. The threat to the form of practice which medicine has followed through generations, created by projected social legislation, has made us all suddenly aware of the importance of public good will. That good will, we have felt, could be obtained if the public understood our motives better, if they appreciated our contributions to society more fully, and if they realized that our outstanding achievements could only have been wrought in an atmosphere of free enterprise and self-sacrificing endeavor.

Vast sums have been appropriated and expended on the national and state level, by medical organizations, to acquaint laymen with our successes and what these successes meant to them. Such knowledge we have felt would make them reluctant to accept the suggestion of change. Columns of the public press have been devoted to a detailing of our professional progress as evidenced by the conquest of one disease after another and the phenomenal lengthening of the average span of human life during recent years. Radio has been employed to present factual information and emotional appeals through radio dramatization of the problems.

In spite of all these approaches there are still not a few individuals who continue to indicate a desire for change in the form and method of medical practice. Frequently, in irritation, we have assigned base motives to those who refuse to understand our viewpoint and occasionally we have accused them of adherence to abhorred political philosophies. When, however, we have canvassed carefully those who support changes, we find all too frequently that their motives are sincere and that their desire for change is based upon a personal and individual unsatisfactory relationship with a physician. They complain that the doctor whose aid they have sought is indifferent in his attitude, or possibly inconsiderate of their economic status in the assessing of a fee. Out of this resentment comes frequently the attitude, "If the doctors are opposed to this change we favor it. It will serve them right." We may feel that such an attitude is superficial and ill-advised, but nevertheless it exists. It is a common human reaction and as such we must recognize and reckon with it. The resentment to the individual is frequently misdirected to the group. Doctors' organizations are infrequently the objects of public antagonism, but when an individual doctor arouses antagonism, this is often transferred to the organization.

The time has come when we must face facts frankly. We do not begin the construction of a building in the superstructure, or in the roof. Our first concern is for the foundation. If this is weak or poorly set up, all the exposed beauty and refinement are good for naught, and it soon crumbles away.

The first and fundamental step in the creation of good public relations is the development of a satisfactory personal relationship between every doctor and his patient. If this exists we shall have little difficulty with the larger problems. If this is absent the problems will prove soluble only with great difficulty if at all.

In our code of ethical practice we have the credo on which sound and satisfactory personal doctor-patient relationships can be built. Have we in our ceaseless pursuit of scientific progress at times become neglectful of these fundamentals? If so, we must rechart our course. Ours is a profession of service. The doctor who strays even temporarily from that ideal must be promptly led back by the pressure of group consciousness and group determination. Membership in medical professional bodies must demand first and foremost a following of the ancient guide-posts of professional conduct. The privilege of being a doctor of medicine carries an obligation not only to the patient but to the profession. Our public relations will be satisfactory when every physician remembers that in every act he is not only an individual but the representative of a profession old in tradition and respected throughout all history.

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* This is the fifteenth in a series of guest editorials by distinguished physicians and laymen.

H. K. Petry, M.D.
President, The Medical Society of the State of Pennsylvania

CANCER

The medical profession has long known the seriousness of the cancer problem. We have watched the increase of cancer gradually bringing a higher and higher death rate. We are all more or less aware of the vast amount of research work being carried out in many and varied laboratories. We know the difficulties of diagnosis especially in deep-seated cancer. And we know, only too well, the utter hopelessness of late diagnosis. Even in the presence of an early or fairly early diagnosis we are not yet agreed on the form of treatment for the various and manifold forms in which cancer occurs.

The recent intensified interest in the cancer problem of the general public brings added responsibilities on the profession. The many questions propounded to us on this subject tax our all too meager knowledge. The mass of suggestive and intriguing facts constantly being accumulated challenge the researcher but as yet are of little value in answering the immediate question of the therapy of cancer. The production of experimental cancer, the studies on heredity and the relation of the hormones to growth all seem to suggest a possible solution but do not alter the difficulties of the family doctor and his inquiring patient.

Many laymen think concentrated high-power research can solve the riddle of cancer as it solved the riddle of atomic energy. We of the medical profession know that the two problems are entirely different. The heroic efforts of many scientists and the expenditure of huge sums of money that brought one dream to fruition will not solve this puzzle. The great multiplicity of the factors bearing on this profound alteration of cell growth precludes a simple or rapid solution to the problem. As yet we know only too little of normal growth. We must answer all the questions on the control of normal growth before we can explain the abnormal growth known as cancer.

We as practitioners of medicine must face the fact that the cancer question in our immediate daily life is a question of early diagnosis and adequate treatment. We can at least from our daily experience dispel the all too prevalent idea that cancer is incurable. Though the cases are only too few, we all know of many, many cures.

The present drive for funds by the American Cancer Society will supply us with much ammunition for an intensified war on this, the second most common killer of mankind. The study of the local prevalence of cancer, now being conducted by Dr. Harold F. Dorn of the National Institute of Health at the instigation of our District Health Officer, Dr. George C. Ruhland, will be an invaluable guide for the future activities of the District of Columbia Division of the American Cancer Society.

With the funds now being collected we propose to establish new cancer prevention clinics throughout the city where the apparently well can have that dread question, "Have I cancer?" as adequately answered as our limited means now permit. We expect every general hospital in the District to establish its cancer clinic according to the standards of the American College of Surgeons.

The care of the indigent terminal cancer cases should also be provided for, either through visiting nurse care or in beds for such sufferers in our expanding hospitals.

As recent studies have shown, the death rate from cancer can definitely be reduced by early diagnosis. By educating the public to recognize the warning signs, by adequate facilities for diagnosis, and by an enlightened profession, the appalling death rate can be reduced.

Harry H. Kerr, M.D.
President, District of Columbia Division of the American Cancer Society

THE PHYSICIAN AND THE MENTAL PATIENT

Every practitioner of medicine has to deal more or less frequently with patients who are suffering from psychiatric disorders. Usually these conditions are of a nature which can be dealt with effectively in the general hospital or in the patient's home. Now and then, however, it becomes necessary, as in the case of suicidal attempts, acute excitement, alcoholic intoxication, or some other serious disturbance of behavior, to arrange for the patient's care in the psychopathic ward of Gallinger Hospital. If the patient is willing to enter that ward "voluntarily" (subject to commitment), he may apply in person, or a "permit" for his admission may be secured from the Hospital Permit Bureau, 468 Indiana Avenue, N.W. Ideally, he should be at liberty to apply voluntarily for admission to Saint Elizabeths Hospital, and it is to be hoped that a law to permit this procedure may be enacted by the present Congress.

Some of these patients, however, lack insight into their condition and are unwilling to go voluntarily to Gallinger. If the patient is found by the police in a "public place," the latter may apprehend him and take him to Gallinger if they consider him mentally ill and in need of supervision. There is another situation in which the police can be of service and in which the physician is involved, namely, that in which the patient is at home or in some other non-public place. The law provides that commitment to Gallinger can be made upon the affidavit of two responsible residents "of the District to the effect that they believe the patient to be mentally ill and potentially dangerous to the public peace," and upon the certificate of at least two physicians "who shall certify that they have examined the person alleged to be insane or of unsound mind, and that such person should not be allowed to remain at liberty and so unrestrained, and that such person is a fit subject for treatment on account of his or her mental condition." The physician executing such a certificate must be licensed in the District of Columbia unless he is a commissioned officer of the Army, Navy or Public Health Service; he must be a permanent resident of the District of Columbia and have been in active practice for at least three years; further, he must not be related by blood or marriage to the patient, and must not be financially interested or officially connected with the hospital to which the patient is sent. The certificate must be based upon a personal examination of the patient made by the certifying physician within forty-eight hours of executing the paper; the necessary forms may be obtained from the Commission on Mental Health, Room 4120, 300 Indiana Avenue, or any police station.

It is unfortunate that this procedure is complicated, and that it illustrates well the statement made nearly ten years ago by Dr. Grover Kempf of the Public Health Service in a survey of the mental health laws of the District, viz., that "the law regards mental illness as a legal problem and not a medical one." However, until more progressive laws relating to the mentally ill of the District are enacted, physicians are bound by the statutes in securing for their patients the benefits of mental hospital care. Eventually, perhaps, the mentally ill patient will be recognized by the law to deserve as ready access to Gallinger and Saint Elizabeths as is now available to his physically ill brethren in the general hospitals. The provision of psychiatric facilities in the new George Washington University Hospital is, in this respect, a favorable augury for the future.

W. O.

In and Out of Focus

BY THE OBSERVER

AMA's New President Thousands of physicians throughout the country were saddened by the news that Dr. Olin West, President-elect of the American Medical Association, had resigned because of ill health. Ailing and discouraged, he wrote the AMA's Board of Trustees, "Because of continued and possibly permanent impairment of health, I feel compelled to submit my resignation as President-elect. . . . It now seems probable that I shall not be able to attend the Centennial Session to be held in Atlantic City. . . 'the spirit is willing but the flesh is weak.'"

Thus comes to a close the active career of a physician more widely known and loved by his colleagues than any other official of the AMA. Most members of the Association's House of Delegates cannot recall when a meeting was held without Dr. West. It seemed somehow that he was an integral part of the AMA, first its long-time Secretary, and finally, its President-elect. To all who know Dr. West, the meeting in Atlantic City will not seem the same without him. It is your Observer's hope, and he is sure that he voices that of many others, that somehow Dr. West's health will improve enough to permit him to participate to at least a limited degree in the activities of the organization to which he has devoted so many years of his life.

Naturally, there is widespread interest in Dr. West's successor, Dr. Edward L. Bortz of Philadelphia. What are his qualifications? Is he experienced in organization work? Will he measure up to his responsibilities? What are his views on the momentous issues which confront medicine? Naturally, some of these questions cannot be answered until Dr. Bortz has been in office for a short time at least. However, his record would justify optimism.

Dr. Bortz, elected Vice President at the June, 1946 meeting in San Francisco, automatically takes over Dr. West's duties, and will be installed as President at Atlantic City. He comes to his task with long experience in organization work. He has been a director of the Philadelphia County Medical Society, Chairman of its Committee on Public Relations, and its President (1940). He has also served as Chairman of the Committee on Scientific Business of the College of Physicians of Philadelphia, and Chairman of the Committee for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania.

A member of the Council on Scientific

Assembly of the American Medical Association since 1942, he became its chairman in 1945. Finally, he is chairman of AMA's Committee on National Emergency Medical Service. He was a member of the Association's House of Delegates in 1945. So it is quite clear that Dr. Bortz will be no novice in dealing with problems confronting organized medicine.

Dr. Bortz was born in Greensburg, Pennsylvania, February 10, 1896. He received his A.B. degree from Harvard in 1920 and the degree of Doctor of Medicine from the same institution in 1933. There followed an internship at Lankenau Hospital (1923–1925), study abroad at the University of Vienna and the University of Berlin (1925–1926), and special work in pathology at the Mayo Clinic and the University of Illinois Medical School. Dr. Bortz then became Instructor in the Department of Pathology at the University of Pennsylvania School of Medicine and the Graduate School of Medicine (1930–1932). He has been Associate Professor of Medicine at the Graduate School of Medicine of the University of Pennsylvania since that time, and also Chief of Medical Service B at Lankenau Hospital.

Anyone becoming head of such a vast organization as the American Medical Association assumes a very heavy responsibility. Dr. Bortz is assured of the good wishes of the medical profession throughout the country and their earnest hope that his administration will be a most successful one. These are crucial years for medicine, and leaders, no matter how well qualified and able, need the enthusiastic and intelligent support of the rank and file of the profession, if they are to succeed.

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New National Health Bill

Your Observer reported in the February, 1947 issue of the Medical Annals that Senator Robert A. Taft was rewriting the health bill which he introduced in the last Congress. The rewritten bill has been introduced and is known as the Taft-Smith-Ball-Donnell National Health Bill (S.545). In general, this legislation is very similar to that previously sponsored by Senators Taft, H. Alexander Smith of New Jersey, and Joseph H. Ball of Minnesota. However, there are modifications with which physicians should familiarize themselves. They will be found in an analysis prepared by the Bureau of Legal Medicine and Legislation of the American Medical Association which appears in the *Journal of the AMA* for March 22, 1947. Space does not permit the publication of this analysis in full, but your Observer wishes to call special attention to what he considers points of particular importance in the new health bill.

"The new bill proposes, as did the one introduced in 1946, to enact a 'National Health Act' and is pending in the Senate Committee on Labor and Public Welfare, of which Senator Taft of Ohio is chairman. Several changes noted in S.545, as compared with the first bill, merit initial comment. In the pending bill it is provided that the administrator of the proposed National Health Agency must be 'a doctor of medicine, licensed to practice in one or more of the states and who is outstanding in the field of medicine.' In the initial bill the administrator was to be either (1) a doctor of medicine with at least eight years of experience in the commissioned corps of the Public Health Service or (2) a doctor of medicine licensed to practice medicine or surgery in one or more of the states, who has had at least five years of active practice and three years of experience in a responsible position in medical research, teaching or administration.

"In the bill introduced in the Seventy-Ninth Congress the United States Public Health Service, acting through the Surgeon General, was designated as the administrative agency on the Federal level in relation to state programs to provide medical and hospital care for families and individuals of low income. The present bill provides for the establishment in the proposed National Health Agency of an Office of Medical and Hospital Care Services to supervise the administration of state programs. The director of this office will be a doctor of medicine who has had at least five years of active medical practice and who is outstanding in the field of medicine.

"A new section in S.545 will authorize an appropriation of $3,000,000 to assist states in surveying the availability of existing medical, surgical and hospital care to persons unable to pay in full therefor. Another new section would authorize an annual appropriation of

$10,000,000 to develop more effective means for the prevention and control of cancer."

Sponsors of this legislation propose to place control over the health services to be provided under the bill in the hands of a new department of the Government to be known as the National Health Agency. Existing departments and institutions having to do with health which would come under the jurisdiction of the Agency are: the United States Public Health Service, St. Elizabeths Hospital, and the Food and Drug Administration. Also to be transferred to the Agency are the Children's Bureau and "the functions and duties of the Division of Health Studies in the Bureau of Research and Statistics of the Social Security Administration." The latter provision has particular significance because it is charged by some opponents of compulsory health insurance that legislative proposals for a government system of medical care originate in this department.

There is no portion of this bill which is of more vital interest to physicians than that relating to medical care. Among other things the bill specifies that the Federal Government shall "assist states to provide general health, hospital, and medical services for families and individuals with a low income." It also provides for medical care surveys, a provision not included in the earlier bill.

States desiring to participate in the program must submit a plan to the director of the program which must:

"1. Designate a single state agency as the sole agency for the administration of the plan or designate such agency as the sole agency for supervising the administration of the plan, 'providing that on or before 1949 such agency shall be the state health agency.'

"2. Provide for the designation by the governor of a state medical and hospital care advisory council, to include representatives of nongovernment organizations or groups, and of state agencies concerned with the administration or utilization of health, medical or hospital services, including representatives of state medical associations, state hospital associations, voluntary nonprofit prepaid hospital plans and voluntary nonprofit prepaid medical care plans, or other groups interested in the improvement of medical and hospital services and in the better distribution thereof.

"3. Contain satisfactory evidence that the state agency will have authority to carry out the plan.

"4. Set forth a statewide program designed and calculated to provide, within five years, (a) hospital services, surgical services and medical services for all those families and individuals in the state having insufficient income to pay the whole cost of such, and (b) periodic physical examination for all children in elementary and secondary schools in the state. Such a program may, (1) at the option of the state, provide medical care services in institutions, in the home or in physicians' offices; (2) provide for the furnishing of such services to such families and individuals by means of payments in the nature of premiums or partial premiums or reimbursement of expenses or otherwise by the state, to any voluntary health, medical or hospital insurance fund, or other fund, operated not for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance therefor; (3) include and take account of services rendered or to be rendered by governmental subdivisions of the state and by private organizations operating not for profit and may provide for the payment to such institutions by the state or subdivision for care to such families and individuals, and (4) include payments to physicians practicing in areas which, without such payments, would be unable to provide sufficient income to attract a practicing physician. The program must provide for the collection of proper charges of less than the total cost of such services from persons unable to pay in whole but able to pay in part therefor.

"5. Describe the financial contribution for the support of the plan to be made by the state, its local subdivisions, and its private institutions, 'which contributions shall be sufficient to carry out the program . . . at the end of said period of five years.' The financial contribution made by the state and its governmental subdivisions must be at least equal to the amount contributed for similar purposes in the year 1946, and at least equal to the Federal aid made available to the state under this legislation. There has been added to the pending bill a new provision to the effect that nothing in it shall 'modify obligations assumed by the Federal Government under other statutes for the medical and hospital care of veterans.' This would seem to mean that if a veteran is entitled to medical and hospital services at Government expense and if such services are supplied through a state program, then the Federal Government will pay the full cost and not merely the percentage it normally would pay for services rendered under a state plan.

"6. Set forth the relative need of the various proposals required to carry out the plan and provide for the proper priority between such proposals, based on such need as financial resources become available.

"7. Be based on a statewide inventory of existing medical, surgical and hospital care, including that provided by the state and by private organization and shall describe in detail the extension of such services to the end that they be furnished without discrimination on account of race, creed or color to all persons unable to pay in full therefor.

"8. Provide that the state agency will make such reports as the director may from time to time reasonably require and afford to the director, on demand, access to the records on which the information is based.

"9. Provide that the state agency will from time to time review its state plan and the operation thereof and submit to the director any modifications thereof which it considers necessary."

The director of the program is authorized under the bill to make administrative rulings, but must consult with the National Medical Care Council, which consists of the director *ex officio*, who serves as chairman, and eight members appointed by the administrator. Five of the eight appointed members must be outstanding in the field relating to medical and hospital care, and at least four of them doctors of medicine. The Bureau points out that three appointive members must be persons acquainted with the need for medical care in urban and rural areas. The Council is authorized to appoint special and technical committees required to carry out the intent of the legislation.

Your Observer is still of the opinion that passage of this legislation by the present Congress is unlikely. However, the fact that conservative Senator Taft is one of the sponsors of this type of legislation should make doctors think. The AMA has already indicated its approval. Personally, your Observer is also in accord with this legislation and what it hopes to accomplish. However, if and when it is enacted, medicine is due for many more changes than most physicians realize.

Taking Stock

Although the civilian population in the District of Columbia did not suffer seriously from lack of medical care during World War II, there were times when the number of practicing physicians was down to a minimum due to withdrawal of doctors for the armed forces. Toward the end of the War only essential services could be provided. Fortunately, the health of the people was unusually good throughout the emergency.

Officials of the Medical Society were, of course, concerned lest the number of doctors drop to below the minimum needed to care for the population. Responsibility for maintaining adequate medical personnel rested largely upon the District Procurement and Assignment Committee, of which Dr. Paul F. Dickens was Chairman. To assure the community and the physicians themselves that there was no cause for alarm, the United States Public Health Service was requested by the District Procurement and Assignment Committee and the Medical Society to determine the ratio of active practicing physicians to population in the District and adjacent counties within the Metropolitan Area. Three surveys were made at intervals of six months to a year, the first being in 1942, and the last in 1945. As a result, the Committee and the Medical Society were kept informed as to the adequacy of medical personnel, thereby reassuring the public and averting any serious shortage of physicians.

In summarizing their findings, Antonio Ciocco and Isidore Altman of the Division of Public Health Methods, United States Public Health Service, reported that between September, 1942 and April, 1943 there was a reduction in practicing physicians from 991 to 910, but in the two years from April, 1943 to April, 1945 the number apparently remained stationary. Noted was a relative increase in the number of specialists and the corresponding decrease in general practitioners. On the other hand, the population in the Metropolitan Area had increased 12 per cent.

There were accordingly 838 persons per physician in September, 1942 as compared to one physician to 1,038 persons in April, 1945. What these studies showed most conclusively was that the patient-load was ever increasing as the average age of physicians in the District rose to new highs.

Two years have now passed since the last survey was made and many changes have occurred. V-J Day brought the war to a close nineteen months ago. Most physicians from the District of Columbia have since returned to practice. In addition, many hundreds of other physicians have come to the District, most of them veterans seeking to establish themselves. Three hundred and twenty-nine physicians were admitted to membership in the Medical Society alone in the year May 1, 1946 to May 1, 1947. The total number of practicing physicians in the District at the present time probably exceeds 1,500. This is merely a guess, however, because no reliable figures are available.

It seemed highly important to the Medical Society's Executive Board that an effort be made to ascertain where the Washington Metropolitan Area stood with respect to the number of physicians as compared to population. Numbers alone, of course, do not mean that the District and nearby counties have an oversupply of physicians. An analysis must be made to determine the specialties represented, those who are engaged in general practice, and their respective patient-loads. It may very well be that the analysis will disclose that this area is well supplied. However, the reverse may also be true, especially as to some of the specialties.

At any rate, the Board decided to seek definite information and directed that a letter be sent to Dr. Thomas Parran, Surgeon General of the United States Public Health Service, requesting the assistance of the Service in making another study. Dr. Parran replied that the Service will be glad to make an investigation of the situation.

This is the first study of its kind undertaken in any urban center in the United States since the War. Results, therefore, should be of more than ordinary interest to physicians, particularly those practicing in large cities.

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History Can Be Interesting

In the discussion which followed his paper at the Conference of State Secretaries and Editors held in Chicago last December, your Observer made the statement that he had gained the impression from readers of the MEDICAL ANNALS that they were not particularly interested in medical history. However, he added that personally he found historical accounts, especially those of a biographical nature, most interesting.

At this point Dr. Morris Fishbein, Editor of the *Journal of the AMA*, arose to express the view that medical history held universal interest among physicians if it was interestingly written. Undoubtedly, Dr. Fishbein is right. For many months past, installments of his history of the American Medical Association have been appearing in the *Journal*. His is not the usual dry-as-dust factual account, but a lively story of important milestones in the AMA's history. Few writers, of course, are as gifted as Dr. Fishbein, although there are others who in a more or less degree share his talents.

The medical profession of the District of Columbia can boast of a competent historian in Dr. John B. Nichols, former President of the Society. Dr. Nichols has just completed a history of the Society from 1909 to 1946, which will soon be off the press. As readers of the MEDICAL ANNALS know, he is a regular contributor to the department, "Washington Physicians of Yesterday." Dr. Nichols is particularly well qualified to write about the medical practitioners of the past in the Nation's Capital. No other physician in Washington knows as much about the history of the Society and its members. He was personally acquainted with all the leading physicians in the city beginning in the 1890's. In recent years he has been less active. Consequently, he is not well known to many younger practitioners.

Those who find pleasure in a close-up of the past would find conversation with Dr. Nichols most enjoyable. They would learn that he is especially well informed not only in regard to medical history but the Civil War, of which he has long been a thorough student. Your Observer recalls one beautiful summer day when he was in the company of Dr. Nichols on an automobile ride through Northern Virginia. As they traveled through the countryside, Dr. Nichols revealed how intimately he knew the campaigns and major incidents of the Civil War.

Among the physicians who have practiced in Washington since the founding of the Republic are many able and colorful figures whose careers have been distinguished because of achievements in their profession or the roles which they played in some historical event. Their lives would provide exciting material for writers of biography and fiction. There have been few physicians with sufficient literary ability to attempt such a task. However, there was one medical practitioner who did. Dr. S. C. Busey, a prolific writer, wrote several books about physicians of early Washington. His active professional career covered a longer period than that of any other medical practitioner in the District. Born in 1828, he lived all of his adult years in the District of Columbia. Death finally came to him in 1901 after a long and fruitful life. Perhaps Dr. Busey's most interesting book was his "Personal Reminiscences." In this book he tried to capture the atmosphere of the times about which he was writing. And he succeeded to a surprising degree despite his formal and sometimes florid style. Frankly stating his dislike for certain individuals, he was often too complimentary of those whom he liked. Nevertheless, his is a fascinating story well worth reading by physicians of our time.

One of the most colorful and dramatic figures in the District eighty years ago was the widely known practitioner, Dr. John Frederick May. Dr. May wrote a footnote in history when he identified the body of Lincoln's assassin, John Wilkes Booth. But this was only an incident in the life of an eminent practitioner of medicine. Dr. May's life will be the subject of a radio broadcast sponsored by the American Medical Association as a part of its Centennial Celebration over the NBC network on May 31. Dr. William P. Herbst, Jr., President of the Society, will speak briefly at the close of the broadcast, contributing his observations on the 100 years of progress in medicine in the Nation's Capital.

Here is an opportunity for Washington physicians to discover that their predecessors were not stuffy old fellows, but as able, alert and vigorous as any physician of our day. In fact, they may learn that their lives are rather commonplace by comparison with those of some of their colleagues of yesterday.

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Red Cross Blood Center

Late in January the Secretary of the Medical Society received a communication from Mr. Nat C. Wilson, Manager of the District of Columbia Chapter of the American Red Cross, outlining the manner in which the local chapter proposed to establish a blood donor center in the District. Mr. Wilson requested "the sponsorship of your organization and its utmost coöperation in aiding us to make available on a free basis the blood needs of the city." Prompt endorsement of the project by the Society was requested.

It was apparent from Mr. Wilson's letter that the proposed blood center was part of a nationwide program. Other Red Cross chapters had or were about to establish similar centers. The District Chapter had been authorized to proceed on the following basis:

> "1. The Chapter will staff at its expense a blood donor center centrally located with properly qualified professional and technical help;
>
> "2. The Chapter will recruit and transport to the center volunteer donors in a sufficient number to meet the blood needs of the city of Washington;

"3. The blood will be made available to those needing it on a free basis at the written request of the patient's physician;

"4. The center for bleeding purposes will be open five days per week, Monday through Friday, and satisfactory arrangements will be worked out for service on the delivery of blood during the evening and night and on Saturday and Sunday. It is contemplated that the reserve stock of blood will be maintained at the center;

"5. To avoid wastage, consideration will be given to the processing of any surplus blood into plasma;

"6. The Chapter will employ sufficient professional staff for typing, but cross-matching will be the responsibility of the hospital."

Understandably, Mr. Wilson wishes the Nation's Capital to have the most modern center of its kind in the country. He says too that "the best professional assistance obtainable" will be sought. In addition, he proposes the appointment of a medical advisory committee of seven members of the District Medical Society. This committee will be appointed by the Chairman of the Chapter after clearance with the Society.

Mr. Wilson's communication was referred to the Society's Section on Pathology and Laboratory Medicine. The Chairman of the Section immediately appointed a subcommittee, which on March 8 submitted the following report:

> "The subcommittee of the Section on Pathology and Laboratory Medicine of the Medical Society of the District of Columbia has considered the proposal of the American Red Cross local chapter to establish a blood bank in Washington, D. C.
>
> "The subcommittee approves the proposal in principle, provided it is developed in conjunction with the Medical Society of the District of Columbia and the established Community Blood Plasma Bank."

The Section promptly endorsed the action taken by its subcommittee and communicated this fact to the Society's Executive Board, which also gave its approval. It now remains for the Society to give final approval to this project. Action will be taken on the proposal at the Annual Business Meeting of the Society to be held on May 7.

That an efficiently conducted and amply supplied blood donor center will render a much needed service to the public and the medical profession is self-evident. Certainly, if those who have so ably directed the affairs of the Community Blood Plasma Bank and the medical profession coöperate with the experienced executives of the District Chapter of the American Red Cross, there should be little doubt as to its success, providing there is the response expected from the public.

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Can Voluntary Hospitals Survive?

In few communities have voluntary hospitals had to struggle more desperately for existence than in the District of Columbia. More than one thoughtful observer has wondered if a few of these hospitals could survive. Generally speaking, however, they have been maintained adequately, but the physical plants of nearly all of them are obsolete, unsafe, and far from being a credit to the community. Obviously they cannot provide the facilities to which patients are entitled.

There are many reasons for this situation, the primary one, of course, being lack of funds. There just is not a sufficient number of people with money to give the financial assistance needed. The dearth of large contributors is especially acute in Washington because of its large transient population. Too many people feel no particular allegiance to the community, and apparently most of them have no personal interest in local institutions and organizations. Even when they are so situated that they can make substantial contributions, they are not inclined to lend financial support. It is not surprising then that many hospital plants are in such a down-at-the-heel condition. Is there a solution to this situation aside from government assistance such as has recently been given George Washington and Georgetown hospitals?

Dr. Nathaniel W. Faxon, who addressed himself to this subject at the Ether Centenary of the

Massachusetts General Hospital in Boston last October, believes there is. He also asks the question if voluntary hospitals can survive in the modern world. While he was primarily concerned with the situation in Boston, specifically the Massachusetts General Hospital, what he had to say also applies to Washington.

Dr. Faxon points out a well known fact that Federal and state income and inheritance taxes have seriously reduced the number of large individual gifts and legacies. The question, he says, is how they are to be replaced.

> "We are passing from a period in which the support of voluntary hospitals was considered to be the philanthropic duty solely of the well-to-do and rich to one in which it is believed that such institutions must be supported by their beneficiaries. Obviously, this means industry and labor, from a corporate standpoint, and employers and employees, from an individual standpoint. It is this conception that has produced so-called 'community chests,' which are built on the principle of supplementing the larger gifts of a relatively small group of citizens by many smaller donations from all classes. As corporate bodies receiving benefits, industrial concerns must support hospitals. Labor, through its unions, whose members also receive benefits, must now assume a similar share of responsibility. Likewise, as individuals, each worker and each member of management must make his contribution either to the hospital of his choice or to the community chest, from which it may be distributed to all hospitals in the community. If the voluntary hospital is to be retained it must be financially supported by its community."

Dr. Faxon speaks highly of the generosity of the Boston citizens and the accomplishments of the Greater Boston Community Fund, but the Fund, he says, is "woefully deficient in meeting the financial needs of the voluntary hospitals of Greater Boston." More must be done by the Fund, he says, or other sources of income must be sought.

Pharmaceutical manufacturers, he believes, should support hospital research, and they should be generous in doing so. Private patients should also pay the cost and perhaps a little more than the cost of their hospitalization. Likewise, semi-private patients should pay their way. Hospitals, he observes, have "traditionally set the ward rate and charged individual patients less than the cost of care." In the Boston area the ward charge is $6.00 a day for board, bed and general service, items that at present cost hospitals $8.00 a day. An additional charge of $3.00 for extras such as X-ray films, operating room and laboratory fees, usually paid by patients, increases the cost to $11.00 a day. Individual ward patients, therefore, contribute $9.00 for services that cost $11.00; that is, 40 per cent of them do. Thirty per cent of them pay only part of the cost, and the remaining thirty per cent are free patients.

Government agencies, such as the Department of Public Welfare and insurance companies responsible under the Workmen's Compensation Act for the hospital care of a patient, do not at present pay the full cost. In fact, the Department of Public Welfare and similar agencies pay $5.00 a day, less than half the cost of hospitalization. Insurance companies pay only $7.75 a day, or $3.25 less than actual cost. The plea is made by Dr. Faxon that Government agencies and insurance companies be required to pay the full cost, which, of course, is only common sense. Your Observer agrees with him that in Boston or any other community such a situation "can scarcely endure."

Dr. Faxon offers three possible solutions: "that hospitals continue to make up the difference between the cost of care and governmental payments, which, unless unexpected and unforeseen sources of income appear, is impossible; that hospitals provide less expensive and, therefore, presumably a lower grade of care for governmental beneficiaries—this is repugnant to physicians, hospital administrators and trustees, who have always striven to give medical care of the same quality, regardless of the patient's classification as ward, semi-private or private, the difference in hospital charge representing only a difference in luxury or privacy of hospital accommodations, and, moreover, an argument for the political demagogue is thus presented; and that the Government pay the full charge or cost of care."

The most important point made by Dr. Faxon, in your Observer's opinion, is that every group in a community should be constantly reminded that the voluntary hospital cannot operate without their financial support. In return, they should be given assurance that these hospitals are efficiently and carefully administered. Then, too, Government, industry, and insurance companies should be obliged to pay the full cost of hospitalization. As to the indigent, sufficient funds should be supplied by community funds for this purpose.

With respect to the voluntary hospitals in Washington, it would seem that steps should be taken now to emphasize to the public that if voluntary hospitals are to be maintained, they must share the responsibility for their survival. Then, too, more funds must be made available for hospitalization for the indigent by community chests. The cost of hospitalization must somehow be paid.

Some may say that voluntary hospitals should be abandoned for Government institutions. To this Dr. Faxon gives this reply: "Private philanthropy and private agencies have almost universally pioneered in medical and social needs that, when demonstrated, have often but not always been accepted in whole or in part by government. Non-profit or, as they are usually designated, 'voluntary hospitals' have been the pacemakers that have set the standards and made the advances. In such hospitals lie our hope and our security."

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Black and White Thinking

None of us are very successful in taking a completely objective view of matters which directly affect us. Even where public issues are concerned, we are seldom as open-minded as we should be. We show our bias in many ways, usually by listening impatiently to those with whom we disagree. Equally familiar is the avoidance of newspapers and other publications which do not reflect our views. If we are Republicans, we do not care to read a Democratic newspaper. Editorial views expressed by such a paper only serve to irritate us. Radio speakers whose opinions do not coincide with our own are promptly tuned out. In fact, we are even inclined to associate only with those who see things pretty much as we do.

Of course there is the rare individual who sees the world about him in its true perspective, but he is decidedly in the minority. Your Observer certainly does not pretend to be in this company, although he believes that he can claim affiliation with a somewhat larger group who manage somehow to keep their emotional equilibrium. How do physicians rate in this regard? Generally objective in scientific matters, they are like most people prone to avoid or to argue vociferously with those who disagree with them in political, social and economic matters.

Some years ago a member of the Society protested vigorously against an invitation being extended to a United States Senator to speak to the Society. The reason lay in the Senator's views with regard to medical care. Officers of the Society took the position that it was extremely important to hear both sides of a controversial issue. If physicians were fully convinced of the soundness of their position, they said, the arguments of those taking a contrary stand would only serve to deepen their convictions.

Your Observer is proud of the fact that our Society has listened respectfully to those with whom a majority of its members disagree. In fact the Society must be credited with having gone beyond just listening to them, for it has published the opinions of dissenters and crusaders for changes in medical practice which its members violently oppose. It has never extended a conditional invitation to a speaker or a writer, nor has it endeavored directly or indirectly to censor his comments.

Among those who have spoken before the

Society have been Senator James E. Murray of Montana, Dr. John P. Peters, Professor of Medicine, Yale University School of Medicine, and Fiorello H. LaGuardia, former Mayor of New York, all of whom are ardent advocates of compulsory health insurance. The largest audience turned out for Mr. LaGuardia, who, in his forthright manner, did not hesitate to tell the doctors and their guests where he stood. He did it, however, very pleasantly, and with much good humor.

In the light of the attitude of our Society toward speakers whom it invites to address its members, your Observer can well understand Mr. LaGuardia's refusal to go through with the Dowling Memorial Lecture at Birmingham Southern College on March 26. It appears that the Jefferson County Board of Health requested him to avoid any reference to socialized medicine. The request was contained in a letter from Dr. George A. Denison, Health Officer of Jefferson County, to Mayor Cooper Green of Birmingham, Alabama, which was forwarded to Mr. LaGuardia. Dr. Denison wrote: "I think it advisable that you write Mr. LaGuardia suggesting that in his lecture here on the 26th that particular reference or discussion of socialized medicine should not be made.

> "He will understand, I am sure, that we have particular reference to such bills introduced into the Congress as the Wagner-Murray-Dingell bill. Certainly we have no reference to such fundamental legislation as the Social Security Act.
>
> "It is not that I, personally, feel that problems relating to socialized medicine should not receive public discussion but rather that the particular group sponsoring Mr. LaGuardia's lecture includes and has a close tie with members of the medical profession and we want to maintain peace and harmony within the family by avoiding the controversial issues."

In reply Mr. La Guardia said, "Regardless of whether I intended to make any such reference, and in all likelihood I would, please be advised that I am not accustomed to having people tell me what to say or what not to say."

Protests that "suggestions relative to your Birmingham speech were suggestions only" failed to placate Mr. LaGuardia, who said, "It is apparent that some of the audience would look for entertainment rather than information. I am not in the entertainment business. . . .I have lost interest and doubt that any useful purpose would be served."

Needless to say, your Observer does not agree with many of Mr. LaGuardia's views on medical care, but he does approve of the position he has taken in this instance. Black and white thinkers in the medical profession should learn from this incident to be more tolerant of the opinions of those with whom they disagree. If hearing both sides is a threat to their convictions, they are not on very firm ground.

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Individualists to the End

In discussions with physicians your Observer has frequently heard such sentiments expressed as: "Doctors are individualists and will never work together"; "There is too much professional jealousy. As long as doctors are as they are, medical organizations will be impotent"; "Look at the cultists, they are much better organized than we are! They pay higher dues and get results"; and "What we need is a union." In view of the number of times such statements have been made to him, your Observer found the editorial, "The Last Individualist," which appeared in the March, 1947 issue of the *Journal of the Medical Society of New Jersey*, of particular interest.

> "Perhaps when the last chapter is written," the editor states, "it will appear that the doctor of medicine resisted longer than any one else the pressure for identification with a group. The grocer goes to work for the chain store, the attorney for the huge law firm. The 'personal' journalist of the small town becomes a copy editor for a chain of newspapers. The columnist is only a single item in a stable of syndicated writers. The once temperamental actor accommodates his schedule to the rules of Actor's Equity and before long we may expect an artist's 'Authority' to regulate even that individualistic activity.

> "But, you say, we doctors have our organizations too. We conform to the rules and ethics of the medical society and to the requirements of a medical practice act. Yes, we conform. But only within the broad limits laid down by law and canon. And those limits are generous indeed. Let a medical society issue a formulary and urge all doctors to limit their prescriptions to its contents. There will be mutterings of 'No one is going to tell me what to prescribe' and the formulary will gather dust on a corner of the desk. A century ago, The Medical Society of New Jersey adopted a fee schedule and tried to discipline members who charged more or charged less. The doctors refused to conform; and refused to be disciplined. A medical society can mould its members only to the extent that they voluntarily accept the moulding. Let any society go one iota beyond this, and its recommendations are ignored."

Commenting on the refusal of doctors to accept strong leadership, the editor says:

> "A truly efficient organization, one that acts swiftly and with complete unity, needs dynamic leadership, with decisions crisply made by those selected to make them, and with power to commit the resources of the organization to the implementing of those decisions. In a medical society, however, there can be no privates or corporals or even sergeants. In medical organization, as in the army [medical corps], we are all officers. We're free-born, fully licensed, responsible only to ourselves. That's the way we want it.
>
> "If some day the entire medical profession finds itself working as employees of hospitals, of the government, or of health insurance companies, we can punch the clock with a warm inward feeling, that anyway, we remained rugged individualists to the end."

Doctors are unquestionably the most individualistic of individualists, especially where their practices are concerned. But your Observer is not so sure that this is true with respect to their organizations. At least not to the extent the editor would have us believe.

In the first place, medical organizations exert much more influence than is generally recognized even by physicians. Many of the privileges which physicians enjoy are due to this fact. For example, medical licensure laws in most jurisdictions eliminate from practice all but qualified physicians. Generally speaking, medical societies, national, state and county, must also be credited with far more effective leadership than is usually attributed to them. The trouble lies in the fact that too many physicians are uninformed with respect to the programs of their organizations, and because they are uninformed, go on the assumption that their organizations are weak and that little is accomplished.

Of course medical organizations vary in effectiveness. Some do act swiftly and with sufficient strength to carry out their objectives. Where such a situation exists, there is confidence in leaders. There will never be complete unity in any organization, but a majority must give their support. Much, therefore, depends on the structure of the organization. Medical societies might well give this matter careful study.

As to discipline and adherence to rules, fee schedules, and so on, your Observer has noted, at least in the District of Columbia, that there has not been too much difficulty on that score. There is no fee schedule in effect to guide physicians in private practice, and in your Observer's opinion, this would not be desirable nor practical. There are Workmen's Compensation and other schedules which must be adhered to, and which physicians cheerfully have accepted. With respect to the rules of the Society as contained in the Society's By-laws, there are a few individuals, of course, who refuse to comply with them, but these are distinctly in the minority.

Your Observer reiterates that organized medicine as represented by its medical societies has greater strength and unity than is generally recognized. Furthermore, the individualism which the physician displays in practice can and does function side by side with coöperative effort.

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Our People in Good Health

So many troubles plague us these days that we welcome good news. One bright spot in an otherwise dark world is the good health of the people of the United States, as revealed in the *Statistical Bulletin of the Metropolitan Life Insurance Company* for January,

1947. According to the *Bulletin* the death rate among the Company's many millions of industrial policyholders in 1946, exclusive of deaths incurred in military engagements, was slightly lower than in 1945, and at the same level as the previous low which was recorded in 1942. Expectation of life also reached a new high, the "provisional figure" being 65.58 years, a gain in 1946 over the previous year of more than one-half year which, according to the *Bulletin*, brings "the total increase to more than five years within the past decade, and to almost 19 years in the past 35 years."

It seems that both sexes shared in the improvement in mortality during the past year, the sole exception being white females 20 to 24 years, who experienced an increase in death rate of 9.5 per cent. Reasons given for this increase are the rise in mortality from external causes, higher death rates from tuberculosis, and diseases of the puerperal state due largely to the upward swing of the birth rate.

The *Bulletin* observes that "the signal victories achieved over childhood diseases in recent years reflect the benefits derived from the newer methods of treatment, including the use of the sulfa drugs and penicillin." Communicable diseases of childhood showed a death rate as low or lower than those of any previous year. There was a slight increase in measles, but 1946, the *Bulletin* points out, was a "measles year."

The tuberculosis death rate also reached a new low in 1946. The rate would have been even better, the *Bulletin* states, had there not been an epidemic of respiratory diseases at the year's beginning. Influenza and pneumonia accounted for a high mortality early in 1946.

Among the diseases which became epidemic in 1946 was poliomyelitis. There were more than 25,000 cases reported throughout the United States, which was the highest since 1916, when there were 29,000. Fortunately, the mortality rate was low in 1946 compared to 1916, there being 1.4 per 100,000 as against 12.2 in 1916.

The *Bulletin* reports that persons of middle age and older were, for the most part, healthier in 1946 than in the previous year, although the "crude rates" indicate a somewhat higher mortality than in 1945. This increase is ascribed to the higher average age of the group studied. Cancer and diabetes showed no change from the 1945 record. On the other hand, cardiovascular-renal diseases registered a decline.

Rather surprising to your Observer was the reduction in mortality due to all types of accidents. Deaths due to this cause dropped by nearly 13 per cent. As might be expected, fatalities due to motor vehicle accidents rose sharply, being at the 1942 level. There was also a 14 per cent increase in suicides. Homicides stood at 4.1 per 100,000 in 1946, the highest since 1939. This would seem to indicate that our people are unstable emotionally, and that many are in need of psychiatric attention.

By and large, the health record disclosed by this study is most satisfactory, and one in which we can take considerable satisfaction.

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So You Will Understand

Most of us really know very little about those with whom we associate. We meet them socially or in the course of our professional or business pursuits and come to believe that we understand them pretty well. Then one day we see a facet of their make-up which is more revealing than all that has gone before. We may also learn something unknown to us about the conditions under which they do their work. Gradually it dawns on us that we had not known them very well after all.

Your Observer has endeavored to keep these facts in mind in his dealings with many persons with whom he comes in touch on a more or less intimate basis. Among other things he endeavors to visualize the conditions under which they labor, for this is to him most revealing. In this he has, of course, not been too successful. As a result he has not made allowances for what appear to be inexcusable deficiencies. However, he has made a real attempt, and on this basis he asks the indulgence and understanding of others, especially those who communicate with him by telephone at the Society's office.

As is well known, the Society's membership has grown tremendously in the past year. The result has been that the Society's office is busier than at any time in its history. Telephone calls have vastly increased; in fact, they have increased to such a point that they have become a serious problem. Days follow each other when the office personnel is on the telephone throughout the entire day. It finally reached a point where something had to be done.

Members should understand that it is the desire of the staff to answer all telephone calls promptly. They recognize that a primary function of the Society is to render service to its members. But important though telephone calls are, and they are important, there are other functions which must be performed, and time must be set aside for them. It may not be generally known, but the Society is not permitted to employ the women on its office staff more than forty-eight hours a week, regardless of compensation; and so, with telephone calls taking up a major part of the day, something had to be done to eliminate the constant interruptions. It was finally decided that the best solution was a "quiet hour" in the morning from 10:00 to 11:00 and from 2:00 to 3:00 in the afternoon. During these periods the telephones are answered by one person in the office who has been instructed to inform callers that calls will be referred to the individual wanted, and he or she will call back. This system has been in effect for the past few weeks and has been most satisfactory. The staff accomplishes more, and at the same time calls received are not neglected. It would appear, therefore, unless there are objections on the part of the membership, that this arrangement will be continued.

There is one other matter which should be mentioned in connection with telephone calls and that has to do with the relaying of calls to an individual at the Society's office. Complaints have been made that operators at the MEDICAL BUREAU respond to Society calls, the calls are then transferred to a secretary, and again to the person wanted, usually the Secretary of the Society. Objections to this procedure are valid, and the new arrangement whereby calls are transmitted directly to the individual called has eliminated any delay where the caller is concerned. Calls are put through directly to the individual wanted. This change was made possible by the adoption of the "quiet hour."

If there are still any shortcomings in the handling of calls at the Society's office, members should notify the Secretary. He is extremely anxious that calls be handled as expeditiously and satisfactorily as possible.

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Footnotes The coming American Medical Association Centennial Session to be held in Atlantic City June 9 to 13 promises not only to be the largest, but most important meeting ever held by the Association. The advance registration has been extremely heavy, and indications are that hotels will not be able to accommodate all those who would like to attend. Because the Association is celebrating the first century of its existence, the program is unusually ambitious and elaborate. Those who attend the meeting this year will be well rewarded * * * Dr. Thomas Parran, Surgeon General of the United States Public Health Service, gave the Kober Lecture at Georgetown University on March 29. Those who attended the Lecture praised it most highly. Dr. Parran declared among other things that "the national picture is gloomy," stating that the Nation needs 95,000 more physicians, 113,000 more dentists, and tens of thousands of additional nurses in order to attain an adequate goal in medical and health personnel by 1960. The lecture in its entirety will appear in an early issue of the MEDICAL ANNALS. * * * In the course of the hearings on the Army-Navy unification bill, General Dwight D. Eisenhower said that "the worst problem" facing the War Department today is the reluctance of medical men to enter the Regular Army. In an attempt to overcome this obstacle, the General stated, there is a proposal before the Budget Bureau to improve the Army Medical Service by employing civilian consultants and increasing the physicians' pay. Also being considered is a plan to combine the Army and Veterans Administration Hospital services * * * What the United Press describes as "the postwar baby boom" exceeds even that of wartime. An estimated 3,440,000 babies were born in 1946, an all-time record, the Bureau of Census announced. In line with the national trend, the District of Columbia birth rate also reached an all-time high last year, there being 25,929 births reported to the Bureau of Vital Statistics. The previous year there were 22,954 babies born in the District. * * * According to Fred L. Lutes, President of the Silver Spring Hospital Association, the feasibility of building a 400-bed hospital midway between Silver Spring and Bethesda to replace the present institutions in the area is being considered. It the plan were adopted, the Suburban Hospital in Bethesda and the proposed Silver Spring Memorial Hospital would be abandoned. Apparently board members of the Suburban Hospital are in favor of the proposal. * * * Stating that there was no way now of detecting mentally ill Government employees early, Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, and one of the Associate Editors of the ANNALS, said, "Congress has indicated it wants some kind of health service within the various agencies. There ought to be included at least a system of psychiatric consultation." * * * "Three men had to fight the war that four should have fought," Major General Lewis B. Hershey said recently. "There is no use talking about equality of responsibility," he continued, "unless you have individuals who are healthy enough to carry their share of the load." He pointed out that if only half the men under 22 who were rejected had been able to serve in the

(*Continued on page 286*)

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, April 28, 1947, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

Active Members

Alger Burr Doland, 3130 Wisconsin Avenue, N.W.
Richard Gitter, 1540 Fort Davis Street, S.E.
Roy Hertz, National Cancer Institute, Bethesda, Md.
Julius G. Kirchick, 2704 Upshur Street, Mt. Rainier, Md.
Joseph Rose, 3800 New Hampshire Avenue, N.W.
George N. Schiff, 1726 Eye Street, N.W.
Charles Waters Thompson, 1851 Columbia Road, N.W.

Associate Members

Mason Morris, Jr., 4402 Reservoir Road, N.W.
Charles T. Nicholson, Jr., 804 Prince Street, Alexandria, Va.
Herman I. Slate, 1008 North Highland Street, Arlington, Va.

The following applicants for membership will be voted on at the meeting of the Executive Board, June 23, 1947:

For Active Membership

Alejandro F. Castro, George Washington University—1942
Carlos A. Dominguez, Dalhousie University, Halifax, N.S.—1936
Henry Leon Feffer, Indiana University—1942
Arnold Henry Gould, University of Arkansas—1942
Ernest Alva Gould, George Washington University—1939
Edwin Presley Hall, Tulane University—1926
Samuel Pendleton Hicks, University of Pennsylvania—1940
Merwin Lester Hummel, Jefferson Medical College—1925
Edward Allen John, College of Medical Evangelists—1944
Paul Sadler Kemp, University of Georgia—1933
Stanley W. Kirstein, George Washington University—1943
Jacob Schiff Light, Johns Hopkins University—1936
Eugene Joseph McDonald, Tufts College—1937
Thornton Tayloe Perry III, University of Virginia—1937
Herbert L. Phillips, University of Nebraska—1925
John Wellington Price, George Washington University—1945
Frank James Sanzaro, Georgetown University—1942
Irving Schulan, Syracuse University—1940
Jefferson J. B. Sebastian, University of Oklahoma—1936
Gordon M. Smith, George Washington University—1943
John Hicks Watson, Hahnemann Medical College—1943
Jonathan Marshall Williams, University of Chicago—1938

For Associate Membership

John F. Brownsberger, College of Medical Evangelists—1925
Alma C. Braun Kelly, Western Reserve University—1943

The Editors' Forum

THE DOCTOR'S SOCIAL RESPONSIBILITY

H. M. Jahr, M.D.
Editor, Nebraska State Medical Journal

Editor's Note: Regular participants in the Conference of State Secretaries and Editors, sponsored annually by the American Medical Association, are well acquainted with Dr. Jahr, a medical editor of long experience. His views are listened to with close attention because of his insight and genuine ability. As readers will discover, here is an editor who knows a great deal about writing.

It is no exaggeration to say that in modern society no other person commands the respect equal to that held by the physician. The average patient looks upon his doctor as a man of learning and understanding. He tells the doctor his innermost thoughts, never fearing betrayal of confidence, always expecting relief from physical or mental discomfort. In generations past this form of hero worship could be explained by the aloofness of the doctor, his disinclination to participate in practical affairs of the world; few people had the occasion to know him away from his professional habitat. The physician of today, however, is a social being who can be seen in the movie, chatted with on the golf course, and even bluffed in a poker game by his own patients. He is a regular fellow, yet he has escaped the proverbial rule that familiarity breeds contempt. His dignity has not suffered.

What is there about the physician that inspires this attitude? It is his professional training toward dispassionate evaluation of his fellow-man, his weakness and his strength, his folly and his wisdom, and all the other attributes which collectively make up his personality. Through numberless centuries of tradition it has become automatic for a doctor to accept the patient primarily as a human being in distress, and to render whatever service is possible to bring about amelioration or cure.

It is this broad-mindedness which makes the individual physician an outstanding character among his patients. That he does not utilize his influence in the sociological sphere is a psychological anomaly. There is no better insurance against present trends in some quarters to undermine the foundation of existing medical practice than that which every physician possesses in his relationship with his patient. There is no implication here that the physician should assume the role of propagandist. He would, however, render a valuable public service if upon every appropriate occasion he acquainted the individual patient with his viewpoints on some of the economic phases of medicine. There is a mutuality of interest in this realm which, properly interpreted, would do much to neutralize the half-truths and the false promises emanating from misguided would-be reformers and false political prophets who honestly or otherwise envision the millenium in government controls.

It may be asked: "Is this type of thinking and discussion suitable for the consultation room? It is not only time-consuming, it is also irrelevant to the purpose for which the patient presents himself in the doctor's office." The fact is that the conscientious physician today has little choice in the matter if he is at all eager to preserve his professional independence. As to how much time is required, that depends upon the disposition of the individual doctor as well as upon the frame of mind of his patient. It is not necessary or desirable to indulge in scientific lectures or long dissertations. Simple statements made in sincerity are more convincing than overenthusiastic rebuttals of arguments of which the patient may or may not be aware. So far as the patient is concerned, the physician is not on the defensive. As to the relevancy of the theme, a well balanced interpretation of the problem should be considered a service which cannot be repaid in fees. For after all the doctor is using his influence not only in behalf of medical practice as a free institution; he is at the same time protecting his patient from blindly falling into the control of a political network of red tape under the guise of "free medical care." The average American loves and reveres his doctor. The doctor in his turn has a social responsibility not only to justify his status but to exert every honorable means in order that this intimate and personal relationship between himself and his patient may be preserved.

LARGE GRANTS BENEFIT G.W.U.

Grants for medical research totaling about $150,000 have been awarded the George Washington University Medical School, which this year is operating the largest research program in the history of the 121-year-old institution.

Largest of the grants is one for $40,000 of public funds for research in anesthesia and the use of penicillin and streptomycin in antibiotics. Those engaged in this project are Dr. Brian B. Blades, Professor of Surgery and administrator of the Medical School research program; Dr. Lloyd Mousel, Clinical Professor of Anesthesiology; and Dr. Monroe James Romansky, Associate Clinical Professor of Medicine.

Six projects are being directed by Dr. Paul K. Smith, Professor of Pharmacology: a study of drugs for treatment of typhus fever and Rocky Mountain spotted fever for the Navy; a study of drugs for treatment of rheumatic fever for the Institute for Study of Analgesic Drugs; a study of drugs that show some promise of impeding tumor growth for the National Cancer Institute; a study of the toxicity of drugs used in arthritis for the American Medical Association; a study of the use of demerol for morphine for Winthrop Chemical Company; and studies of drugs for relief of muscle spasms for Bilhuber-Knoll Corporation.

Penicillin research for the Lederle Laboratories is being conducted by Dr. Harry F. Dowling, Clinical Professor of Medicine, who is studying treatment of various infections with penicillin, new preparations of penicillin, and treatment of various infections with streptomycin.

Under the supervision of Dr. Errett C. Albritton, Professor of Physiology, a contract with the United States Public Health Service is being executed to study endocrine factors in the self selection of diet by rats and the validity of self selection of diet by rats as an instrument with which to investigate metabolism of the animal.

Research in hypertension is being continued by Dr. Paul F. Dickens, Clinical Professor of Medicine, under a grant from the Cecelia Cummings Fund set up by Homer S. Cummings, former Attorney General of the United States and a trustee of the George Washington University.

A grant to assist Dr. Joseph H. Roe, Professor of Biochemistry, in continuing research on the methods for the determination of vitamin C in plant and animal tissues has been made by the Nutrition Foundation, Inc., of New York. Dr. Roe did research on this subject for the National Research Council during the War.

Under a contract with the Department of Surgery, Dr. Jacob J. Weinstein, Associate in Surgery, is directing an investigation of protein metabolism in surgical diseases and use of protein therapy parenterally and orally in both pre- and postoperative care of surgical and allied diseases.

A number of special studies are being carried on this year by private donations for special studies in cardiovascular disease under the University's Cardiology Research Fund. These include studies involving use of multiple and special leads in taking electrocardiograms by Dr. Benjamin Manchester, Associate in Medicine, and Dr. Clayton B. Ethridge, Assistant Clinical Professor in Medicine; a paper has just been completed by these two doctors in collaboration with Dr. Irving Wolfe Winik, Associate in Medicine. Work is being continued in the department on the use of newer type drugs in the treatment of vascular diseases. A new method for producing prolonged local sympathetic nervous system block by iontophoresis is being sought by Dr. Manchester.

Other research being carried on this year by grants from the University includes a study of the effect of vitamin E on the vascular system of rats by Dr. Ira R. Telford, Assistant Professor of Anatomy, and experimental vascular surgery in dogs by Drs. Blades, Smith, and Charles Stanley White, trustee of the University.

Washington Physicians of Yesterday

DANIEL SMITH LAMB, A.B., A.M., M.D., LL.D., Sc. D.

Dr. Daniel Smith Lamb was born May 20, 1843, in Philadelphia, Pennsylvania. He was educated in the schools of his native city, receiving the degrees of A.B. and A.M. At the outbreak of the Civil War he enlisted in the Pennsylvania Volunteers, and served throughout the War, mostly in the military hospitals of Alexandria, Virginia. He was a Hospital Steward 1864–68, and Acting Assistant Surgeon, United States Army, 1868–92. During this time he studied medicine, and in 1867 graduated with the degree of M.D. from the Georgetown University School of Medicine.

From 1865 until retirement in 1920 he rendered highly distinguished service as Pathologist of the Army Medical Museum; he was practically (though not officially) the curator of that institution and was a major factor in its upbuilding. With the vast amount of material at his disposal, Dr. Lamb became profoundly versed in pathology, anatomy, and collateral subjects. He had extensive autopsy experience, and made historic postmortem examinations of President James A. Garfield, Vice President Henry Wilson, and the assassin Guiteau. A graceful and forceful writer, he made voluminous contributions to medical and allied literature; his bibliography included some 250 items, mostly

(Continued on page 286)

News and Personals

The American Medical Association has issued its official call to officers, Fellows and members of the Association, requesting their presence at the ninety-sixth annual session, celebrating its centennial year, which will be held in Atlantic City, New Jersey, from Monday, June 9, to Friday, June 13, 1947.

The House of Delegates will convene on Monday, June 9, at 10:00 a.m. in the Rose Room of the Hotel Traymore.

The Scientific Assembly of the Association will open with a General Scientific Meeting on Monday, June 9, at 2:00 p.m.

The General Meeting at which the President will be installed will be held on Tuesday, June 10, at 8 p.m. Dr. Olin West, President-elect, has resigned because of ill health. Dr. Edward L. Bortz, Philadelphia, Vice President, will succeed Dr. West and will be inaugurated as President.

The various sections of the Scientific Assembly will meet Wednesday, June 11, at 9 a.m. and at 2 p.m. and subsequently according to their respective programs.

The Registration Department will open at 8:30 a.m. on Monday, June 9.

A large delegation from Washington will attend these meetings. Representing the Society officially will be Drs. Coursen B. Conklin and Herbert P. Ramsey, Delegates to the American Medical Association, and Theodore Wiprud, Secretary of the Medical Society.

As part of its centennial program, the AMA is broadcasting a special series of dramatizations in its regular weekly program, "Doctors—Then and Now." These dramatizations will be a half hour in length and will feature pioneer doctors of various sections of the United States during the past hundred years.

At the request of Dr. W. W. Bauer, Director of the Bureau of Health Education of the AMA, the Society's Committee on Radio Education recommended to the Executive Board for this role Dr. John Frederick May, who identified John Wilkes Booth following the assassination of President Lincoln. The broadcast featuring Dr. May will be heard over the NBC network, May 31, at 4 p.m., Eastern Daylight Saving Time.

CALENDAR OF MEETINGS

April 1	Women's Medical Society
April 8	Board of Trustees, Medical Service
April 9	Woman's Auxiliary Undergraduate Practical Nurses Association
April 11	Committee on Public Meeting, Annual Scientific Assembly
April 12	Washington-Baltimore Psychoanalytic Society
April 14	First Postgraduate Lecture on Diagnosis Committee for Expansion and Rehabilitation of the Hospital Facilities of the District of Columbia
April 16	Scientific Meeting of Society
April 17	Washington Metropolitan Health Council
April 18	Board of Censors
April 21	Second Postgraduate Lecture on Diagnosis
April 23	Committee for Expansion and Rehabilitation of the Hospital Facilities of the District of Columbia
April 25	Committee on Arrangements, A.S.A.
April 28	Executive Board Third Postgraduate Lecture on Diagnosis Subcommittee on Scientific Exhibit, A.S.A.
April 30	Scientific Meeting of Society Committee on Public Policy

The Society for Vascular Surgery will hold its first annual meeting on June 8, at the Dennis Hotel, Atlantic City, New Jersey. The program will begin at 2:00 p.m. The principal speakers will be Drs. Alton Ochsner, Emile Holman, Alfred Blalock, Robert E. Gross, Arthur H. Blakemore, Géza de-Takats, Harris B. Shumacker, Robert R. Linton, and Michael E. DeBakey. At 8:00 p.m. there will be a panel discussion of the papers presented during the afternoon. All physicians are invited to attend the meeting.

The 24th Annual Meeting of the American College of Radiology will be held on Sunday, June 8, at 3 p.m., at Haddon Hall in Atlantic City, N. J.

The National Gastroenterological Association will convene for its 12th Annual Convention and Scientific Sessions at the Hotel Chelsea in Atlantic City, New Jersey, June 4-6, preceding the centennial meeting of the AMA. Programs and further details may be obtained from the N.G.A., 1819 Broadway, New York 23, N.Y.

The Third American Congress on Obstetrics and Gynecology will be held in St. Louis, September 8-12, 1947. Requests for space in the Scientific and Educational Exhibits should be made at an early date. Necessary blanks may be obtained from the office of the Congress, 24 West Ohio Street, Chicago 10, Ill. Dr. John Parks of Washington is in charge of the motion picture program.

The headquarters office of the **Woman's Auxiliary to the American Medical Association** has been moved to the American Medical Association's building at 535 North Dearborn Street, Chicago.

The American Hearing Society has requested the Medical Society to publish an announcement of the **Kenfield Memorial Fund** (in the amount of $100 for 1947) which is being offered to prospective teachers of lip reading. Physicians are urged to inform any persons with aptitude in this field to file application before June 1, 1947 with Miss Rose V. Feilbach, 2431 14th Street, N.W., Washington 9, D. C. Miss Feilbach will be glad to furnish the applicant with a list of the requirements which must be met.

The Woman's Auxiliary to the Southern Medical Association has established the **Jane Todd Crawford Student Loan Fund in Gynecology** for young Southern physicians wishing to pursue the study of gynecology. In 1809 Dr. Ephraim McDowell successfully removed a large ovarian cyst without anesthesia or antisepsis from Jane Todd Crawford, for whom the loan fund has been named. The patient by her bravery has become a symbol of heroism.

The applicant should not be over 32 years of age, of good character, and showing evidence of being capable of absorbing adequate knowledge. The loan must be returned in small installments after completion of his studies. Inquiries may be addressed to Mrs. J. Ullman Reaves, 1862 Government Street, Mobile 18, Alabama.

The Director of the Bureau of Venereal Diseases, District of Columbia Health Department, announces that there is a position open for a **Clinical Director P-5** to direct a clinic staff of 36 in a venereal disease clinic with 10,000 new admissions yearly. Experience required: one year in venereal diseases or an equivalent training in dermatology and syphilology. Salary: $5,905.20 to $6,862.80. Civil Service status and retirement on same basis as Federal employees. Interested inquirers may call or write to Dr. S. Ross Taggart, Director of the D. C. Bureau of Venereal Diseases, Municipal Center, Washington, D. C., telephone National 6000.

The Medical Society's Committee on Postgraduate Education sponsored a series of **Postgraduate Lectures on Diagnosis II** at the Medical Society's building on three successive Monday evenings, April 14, 21 and 28. Lecturers and their subjects were as follows:

- *April 14*—"Headache," E. Charles Kunkle, M.D., Research Fellow in Medicine, New York Hospital
- *April 21*—"Convulsive State," William G. Lennox, M.D., Assistant Professor of Neurology, Harvard Medical School; President of the International League against Epilepsy
- *April 28*—"Coma," Howard F. Root, M.D., Associate in Medicine, Harvard Medical School; Physician in Chief, New England Deaconess Hospital

The American Association for the Study of Neoplastic Diseases held a three-day meeting in Washington, April 17, 18 and 19. Most of the sessions were held in the Kellogg Building at Garfield Memorial Hospital. Participating in the program were Drs. T. Clarence Cohn and George A. Stewart, of Baltimore; Dr. George W. Ramsey, Washington Hospital, Washington, Pa.; Dr. Roy Hertz, National Cancer Institute, Bethesda, Md.; and Drs. Roger M. Choisser, Oscar B. Hunter and Janvier W. Lindsay of Washington. Dr. Eugene R. Whitmore is Secretary of the Association.

Most of the following physicians, who were appointed **consultants to the staff of the U. S. Naval Hospital** at Bethesda, Md., on April 21, 1947, are members of the Medical Society:

Dermatology: Edwin E. Barksdale
Medicine: Walter A. Bloedorn, Paul F. Dickens, Clayton B. Ethridge and William T. Gibb
Neurosurgery: Gayle Crutchfield
Ophthalmology: Harold R. Downey and L. Conner Moss
Orthopedics: Paul B. Magnusen
Pathology: Charles Geschickter
Proctology: Vincent T. Young
Psychiatry: Robert Cohen, Lawrence Kolb and David Rioch
Radiology: Joseph F. Belair and Ralph M. Caulk
Surgery: Robert J. Coffey and Charles S. White
Urology: Alan J. Chenery and William P. Herbst, Jr.
Oncology: Calvin T. Klopp
Thoracic Surgery: Brian B. Blades and R. K. Hollingsworth

The Ophthalmic Pathology Club held its first meeting, April 15 and 16, at the Army Institute of Pathology. This group is composed of outstanding ophthalmic pathologists from all over the United States who will meet once a year for two to three days at the Army Institute of Pathology to interchange ideas on pathology of eye conditions. Case presentations were made at this first meeting by Drs. James N. Greear, Benjamin Rones and M. Noel Stow, who are members of the Club.

The 28th Annual Session of the American College of Physicians was held in Chicago at the Palmer House, April 28 to May 2. **Dr. Walter Freeman** participated in a panel discussion on "Psychomatic Medicine" on April 30. At a clinic at Billings Hospital he presented a paper on "Pain Mechanisms and the Frontal Lobes: A Study of Prefrontal Lobotomy in Intractable Pain."

On May 2, **Dr. Wallace M. Yater,** head of the Yater Clinic and Civilian Consultant to the Army Institute of Pathology, lectured on "Clinical and Pathological Comparison of Coronary Artery Disease in Different Age Groups." He also participated in a panel discussion on "Cardiology."

With Dr. Thomas C. Laipply of Chicago, Dr. Yater presented a Clinico-Pathologic Conference, May 1, at Wesley Memorial Hospital.

The Executive Board at its meeting, March 24, appointed **Dr. William L. Howell** to represent the Society on the Organizing Committee for the Fourth International Congress on Tropical Medicine, which will be held in Washington in April, 1948.

The Board accepted with regret the resignation of **Dr. John R. Cavanagh** as Chairman of the Committee on Medical Care for Veterans and as a member of the Committee on Service Physicians. He informed the Board that he was returning to active duty with the Navy.

Dr. Oscar B. Hunter was reëlected to the Board of Trustees of Group Hospitalization, Inc., to succeed himself.

Dr. Carolyn Pincock was appointed the Society's representative on an Advisory Committee to the Summer Round-up at the request of the District of Columbia Congress of Parents and Teachers, Inc. A meeting of the committee was held on March 10.

Dr. Joseph A. Murphy was appointed to represent the Society at the Conference on Coöperation of the Physicians in the School Health and Physical Education Program to be held in Chicago on October 16 and 17, 1947.

The Section on Gastroenterology held a buffet dinner, April 14, at the home of Dr. J. P. Shearer, which was followed by a scientific session and election of officers. Dr. Thomas Arthur Johnson was the guest speaker. Dr. Johnson is Associate in Gastroenterology at the University of Pennsylvania Graduate School and Assistant Physician at the Presbyterian Hospital, Philadelphia. His subject was "New Concepts in the Diagnosis of Diseases of the Pancreas."

The following officers were elected for 1947–48:

Dr. Leo V. Brown, *Chairman*; Dr. Joseph P. Shearer, *Vice President*; Dr. Robert Sterling McGrath, *Secretary-Treasurer*.

At a meeting of the **District Social Hygiene Society,** April 10, Dr. William P. Herbst, President, appointed a special committee to study proposed legislation intended to protect the city from "sex crimes," the findings to be reported to the House District Committee. The bill to be studied by the committee was introduced by Representative MacKinnon (Republican) of Minnesota. It is aimed at bringing "persons having a psychopathic personality" under District laws relating to insane persons.

The members of the Committee appointed by Dr. Herbst were as follows: James V. Bennett, Chief of the Federal Bureau of Prisons; Judge Fay L. Bentley of the District Juvenile Court; Dr. J. R. Heller, Chief of the Division of Venereal Disease, U. S. Public Health Service; Captain Rhoda Milliken, Chief of the Women's Bureau of the Metropolitan Police Department; Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital; and Ray H. Everett, Executive Secretary of the Social Hygiene Society.

The Washington Medical and Surgical Society held its last meeting of the season, March 24. Dr. William M. Clopton presented a paper on "Osteogenesis Imperfecta," and Dr. T. Frazier Williams gave a case report on parapharyngeal abscess. The Society paid tribute to the late Dr. E. Leonard Goodman, past President of the organization, who died February 28, 1947.

The fiftieth anniversary of the founding of the **Episcopal Eye, Ear and Throat Hospital** was celebrated on April 8. Among those honored at a reception in the nurses' home at 1440 M Street, N.W. was Dr. Louis S. Greene, who has served on the hospital staff from the time it was established. The Right Rev. Angus Dun, Bishop of Washington, and President of the Hospital's Board of Corporators and Board of Governors, praised the work of Dr. Greene and of Henry P. Blair, Vice President of the Board of Governors and the only remaining active member of the Hospital's 100 original corporators.

On May 25, 1896, four physicians met in the office of Dr. E. Oliver Belt to discuss the establishment of an institution to care for patients with eye, ear and throat diseases. In addition to Dr. Belt the physicians were Dr. William H. Wilmer, noted ophthalmologist, for whom the Wilmer Institute at Johns Hopkins Hospital was named, Dr. J. H. Bryan and Dr. T. Morris Murray. They decided to make the proposed hospital independent of Congressional aid and to request church sponsorship.

In response to an appeal signed by thirty prominent physicians which was directed to the Right Rev. Henry Yates Satterlee, Bishop of Washington, the Episcopal clergy agreed to support the hospital as an active charity. The diocese itself was just a little more than a year old at the time.

Episcopal Hospital was opened April 8, 1897, in a leased house on the southwest corner of 17th and L Streets, N.W. It had a capacity of 15 beds, with 3 rooms for private patients and 4 free wards of 3 beds each. There was only one trained nurse to assist the superintendent.

The original staff included Drs. Wilmer, Bryan and Belt and Drs. Franck Hyatt, William H. Fox and Charles W. Richardson.

Within seven years the demand for the Hospital's services had increased to a point where it was necessary to move into a new building constructed at the present location, 1147 15th Street, N.W. The change was made in May, 1904.

During the 50 years of the Hospital's existence, it has handled 1,351,000 dispensary visits and performed 150,000 operations. The institution has now a capacity of 100 beds and maintains an extensive dispensary service.

The Mid-Atlantic Section of the American Urological Association closed its two-day conference at the Hotel Statler, March 22, with a business session at which the following new officers were elected: Dr. G. G. Irwin, of Charleston, W. Va., President, succeeding Dr. R. M. LeComte, Washington; Dr. T. R. Fetter, of Philadelphia, Vice President; Dr. H. N. Dorman, Washington, Secretary-Treasurer; and Dr. Charles Uhle, Philadelphia, member of the Executive Committee.

Guest speaker at the meeting of the **George Washington University Medical Society,** April 19, was Dr. George P. Robb, whose subject was "Angiocardiography." Dr. Robb is a consultant in cardiology to the Surgeon General of the Army and Associate Professor of Clinical Medicine at George Washington University School of Medicine.

During the business meeting four physicians were elected to membership, namely, Drs. Charles W. Jones, W. S. McCune, Vincent M. Invine and Leonard T. Peterson. Drs. Everett J. Gordon and S. Arthur Linde were named associate members.

The Smith-Reed-Russell Society of George Washington University School of Medicine held its annual banquet, March 19, at the Hotel 2400. Dr. Rolla E. Dyer, Director of the National Institute of Health, spoke on "The Role of Research in Preventive Medicine." Dr. Brian Blades, Dr. James J. Feffer and Dr. Dyer were elected to honorary membership in the Society.

The Graduate Nurses' Association was host to delegates to the Congress of the International Council of Nurses which met in Washington for a week beginning May 4. The local Association is an affiliate of the American Nurses' Association. This was the first conference since the War and the second time the Council has met in the United States, the previous time being in Buffalo, New York, in 1901. Representatives from 31 nations were in attendance.

A new journal, *The Annals of Western Medicine and Surgery*, has been received in the Medical Society's office. It will be published monthly by the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Los Angeles, California.

Dr. Robert J. Coffey will become Professor of Surgery at Georgetown University School of Medicine, July 1, when the resignation of Dr. Fred R. Sanderson becomes effective. On the same date **Dr. Edward B. Tuohy** will assume his new duties at Georgetown as Director of the Department of Anesthesiology.

Dr. Coffey graduated from Georgetown University School of Medicine in 1932. He received the degrees of M.S. and Ph.D. in medicine and surgery from the University of Minnesota, and was appointed a Professor of Experimental Surgery and Instructor in Clinical Surgery at Georgetown in 1938. He was surgeon aboard the *U.S.S. Iowa* during the War. After four years of service in the Naval Medical Corps, attaining the rank of Lieutenant Commander, he returned to private practice in January, 1946. Dr. Coffey is a consultant in surgery at Mount Alto Hospital, the Naval Medical Center, and the Army Air Corps Hospital.

Dr. Tuohy graduated from the University of Pennsylvania School of Medicine in 1932. A member of the staff of the Mayo Foundation since 1933, he is at present Associate Professor of Anesthesiology. He is President of the American Society of Anesthesiologists.

Dr. Sanderson, who retires as Professor of Surgery, July 1, has been a member of the faculty of Georgetown University School of Medicine since 1923, and will continue on the staff as Clinical Professor of Surgery. Since the death of Dr. James A. Cahill in 1942, he has been Chief of the Department of Surgery of the Hospital and Medical School. Dr. Sanderson served as President of the Medical Society of the District of Columbia for the year 1943–44.

Dr. Hugh Hudson Hussey, Associate Professor of Medicine, Georgetown University School of Medicine, addressed the Hartford Medical Society, at Hartford, Conn., April 7, on the subject of "Chest Pain." Earlier in the day Dr. Hussey conducted a clinic on "The Recognition of Pulmonary Embolism" at St. Francis Hospital, Hartford.

Surgeon General Norman T. Kirk has recently appointed four leading physicians as **Honorary Consultants to the Army Medical Library.** They are Major General Paul R. Hawley, U.S.A. (retired), Medical Director of the Veterans Administration; Dr. Michael E. DeBakey, Associate Professor of Surgery, Tulane University Medical School; Colonel Albert G. Love, M.C., U.S.A. (retired), formerly Assistant Surgeon General; and Dr. Elliott C. Cutler, Mosley Professor of Surgery, Harvard University Medical School. The Association of Honorary Consultants to the Army Medical Library, which now has 97 members, serves as an advisory body to the Surgeon General on matters pertaining to the Library.

The Legion of Merit has been awarded to **Colonel Edmund Horgan, M.C., A.U.S.,** of Delaplane, Va., who performed exceptionally meritorious services at Foster General Hospital and later at Brooke General Hospital from January 1943 to March 1946.

As noted in the citation, in his capacity as chief of the surgical service he was responsible for the organization and the close supervision of all personnel concerned with surgery at these two hospitals. The prompt and efficient handling of serious medical and surgical cases under his care insured completeness of treatment and the attainment of maximum benefits. By stimulating younger surgeons to higher attainment and by his thoroughness of technical training he reflected great credit on himself and on the Medical Department. Dr. Horgan was an Active member of the District Medical Society from 1921 to 1946. He graduated from George Washington University School of Medicine in 1908 and entered the military service on March 2, 1943.

Dr. Henry C. Macatee was reëlected President of **Health Security Administration,** April 9, by the Administration's Board of Trustees. Also reëlected were Dr. Watson W. Eldridge, First Vice President; Dr. Oscar B. Hunter, Sr., Second Vice President; and Frank A. Birgfeld, Treasurer. Mrs. H. K. Willard was chosen to succeed William J. Flather on the Executive Committee, while Dr. Margaret M. Nicholson and John S. Gorrell were reëlected to membership on the Committee. Willard C. Smith was reëlected Administrator and Secretary of the Board.

Surgeon General Thomas Parran of the USPHS was one of the speakers at the 111th annual meeting of the American Chemical Society, April 17. Dr. Parran's address was entitled "The Public Health Service and Industrial Pollution."

The Regional Meeting of the American College of Physicians for the states of Maryland, Delaware and the District of Columbia was held in Baltimore, April 5. **Dr. Joseph M. Barker** of the Yater Clinic, as Associate member of the College, spoke on "Paroxysmal Supra Ventricular Tachycardia with Functional Auricular Ventricular Block."

Dr. Walter R. Stokes took part in the Tenth Annual Conference on Conservation of Marriage and the Family at the University of North Carolina, Chapel Hill, April 8–10. He contributed a paper on "Ways in Which a Physician May Assist Those Engaged in Marriage Counseling," and presided at the closing session of the Conference.

Dr. Stokes gave a talk on "Your Physical Self and Marriage," April 16, as part of a local marriage counseling series for employed girls. The course was held at the Y.W.C.A.

At the request of the Parent-Teacher Association of McKinley High School he participated in a panel discussion on post-season athletic contests.

Dr. Winfred Overholser spoke at a dinner meeting of the Society for Personnel Administration, March 31, at the Y.M.C.A. His subject was "Implication of Psychiatry for Personnel Administration."

Dr. James A. Gannon addressed the Association of Undergraduate Practical Nurses at its meeting, April 9, in the Medical Society's building. He discussed the merits of licensing practical nurses in the District of Columbia, which is one of the Association's objectives. Miss Mary E. Bednarick was reëlected President of the Association.

To **Dr. George J. Brilmyer** go the apologies of the News Editor for stating in the March issue of the ANNALS that he had accepted an administrative position only, at the U. S. Veterans Hospital, Aspinwall, Pa. "While some of my work is administrative," Dr. Brilmyer writes, "I am the Staff Pathologist and Chief of the Laboratory Service. I examine all surgical specimens, gross and microscopic autopsy specimens, and direct all the laboratory work."

During the past several weeks additional Medical Society members, not previously listed in the MEDICAL ANNALS, have participated in the programs of Professional Staff Proceedings at **Walter Reed General Hospital.** They are Drs. William A. Howard, Robert Stolar, Darrell C. Crain, Jr., Alva D. Daughton, and Paul Chodoff.

Dr. Lloyd G. Lewis was the guest speaker at the monthly medical staff meeting at Veterans Administration Hospital, April 7. His paper was entitled "Testicular Tumors." Dr. Lewis was formerly connected with the Brady Urological Institute of Johns Hopkins Hospital and during the War served as Chief of Urology at Walter Reed General Hospital.

Dr. Leonard T. Peterson addressed a class of graduate Red Cross Nurses' Aides, April 9, in the auditorium of the George Washington University School of Medicine. This class was the first in a brief course set up to train "polio emergency volunteers" for the summer months. Miss Elaine Whitelaw, Director of Women's Activities for the National Foundation for Infantile Paralysis, of New York, was present to launch the new volunteer program.

Polio emergency work inaugurates a new peacetime phase of the program of the District Red Cross Nurses' Aide Corps, which still maintains a membership of 400 volunteer nurses' aides serving in various hospitals here.

Dr. Robert Scott Lamb was installed as President of the District Society of the Sons of the American Revolution at its annual meeting at the Mayflower Hotel, April 19.

Dr. Daniel F. Lynch discussed "Osteomyelitis of the Mandible" at a recent meeting of the Washington Section of the International Association for Dental Research. The meeting was held in the South American Room of the Hotel Statler, April 16.

Dr. Dexter M. Bullard addressed the Montgomery County lawyers, April 23, in the second of a series of ten lectures designed to promote better understanding between psychiatrists and attorneys. The course is sponsored by the County Bar Association. Dr. William Welch of Rockville, Md., gave the first address.

CORRESPONDENCE

WASHINGTON, D. C., April 11, 1947

EDITOR, MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA
1718 M STREET, N.W.
WASHINGTON, D. C.

DEAR SIR:

Will you please print the following letter in the ANNALS?

Dear Members:

A Bill is about to be presented to Congress which will provide for the registration, licensing, and regulation of practical nurses in the District of Columbia. The public schools are now conducting classes for the instruction of young women who desire to become practical nurses, and it is expected that the hospitals will furnish the required clinical experience. So, eventually, the practical nurses' situation should be satisfactory to everybody.

The practical nurses who are now practicing are on the whole earnest and sincere women who will continue to nurse if they can furnish evidence of satisfactory service thus far. These women feel the need of adding to their information and experience in order that they may compete with their younger sisters after the youngsters have been formally trained. In order to obtain this information, they need refresher courses.

The Undergraduate Practical Nurses' Association has asked me to try to interest you in their behalf. They have arranged to occupy a classroom at Central High School each Monday evening from 8:30 to 9:30, and they hope that some of the members of the Medical Society may be willing to give them one or more lectures. I feel that your response to their plea will be prompt and satisfactory. If you are willing to help, won't you write to me today, stating what subjects you would like to lecture upon? Any phase of medicine, surgery, obstetrics, gynecology, or laboratory procedure would be in order. When I hear from you I will try to arrange a course which will have sequence. I will notify you as to the date or dates when you will be expected at Central High School.

You will be benefiting the practical nurses, the public, and, incidentally, yourselves, because you will obtain better service.

Sincerely,
JAMES A. GANNON, M.D.
1915 BILTMORE STREET, N.W.

BOOK REVIEW

Men Under Stress. ROY R. GRINKER, Lt. Colonel, M.C., A.U.S., Graduate of the University of Chicago and Rush Medical College; former Fellow of the Rockefeller Foundation; formerly Chairman of the Department of Neuropsychiatry of the Michael Reese Hospital; AND JOHN P. SPIEGEL, Major, M.C., A.U.S., formerly of the Department of Psychiatry of the Michael Reese Hospital. Price, $5.00. Pp. 484. Philadelphia: Blakiston, 1945.

The idea conveyed succinctly in Pope's "A little learning is a dangerous thing" may by extension be expressed thus: "A necessary condition for passionate and uncompromising opposition to a given subject is to know very little about that subject."

It is in the light of the above that I wish to consider what underlies the frequently encountered "passionate and uncompromising" hostility toward the newer concepts of psychosomatic medicine and psychiatry. This unenlightened hostility is still seen in a discouragingly great number of physicians, young and old. Such hostility bodes no good for the future of medicine and a consideration of means to correct or "convert" such hostile physicians is clearly of more than mere academic interest.

From what has been stated it would follow that education in psychiatry is the indicated remedy. If the possessors of such hostile attitudes can be induced to learn more about psychiatry and psychosomatic medicine, it may reasonably be expected that their "passionate and uncompromising" hostility will be diluted at least partially.

It may further be pointed out that this hostility is the expression of the physician's awareness of his inability to cope adequately with psychogenic disorders. It will be seen then as quite to be expected that the physician who has little understanding of factors which he disparages as "neurotic" or "neurogenic" (he is often unwilling to use the term psychogenic) should feel insecure and thus hostile to situations which point up his inability. Further consequences of such hostility include fobbing off the patient with nonspecifics or placebos, often with rather macabre amusement at the patient's occasionally obtaining relief from some of his bizarre symptoms; angry dismissal of the patient as a "damned neurotic"; or, quite frequently seen, a "common-sense" attitude which attempts to "knock the hell out of the symptoms" by argument, persuasion, threats or "If you'd stop thinking about yourself, you'd be better off."

Many current books provide an excellent means of educating such hostile physicians into increased feelings of security in the presence of psychogenic symptomatology. "Men Under Stress" is such a book.

"Men Under Stress" is an account by two Army Air Forces psychiatrists of their experiences in treating war neuroses (euphemistically termed "operational fatigue") among flight personnel in the zone of combat and later in hospitals in this country. This book complements the authors' previously published (by the Army) "War Neuroses in North Africa" (1943), which dealt with neuroses seen in ground troops. (This latter book has been republished [1945] under the title of "War Neuroses.")

"Men Under Stress" devotes its early chapters to considerations of the types of men who desire to become flyers and the various "abnormal" drives that motivate some men in their desire to fly. The combat situation is analyzed, showing how the conditions of war, especially in the air forces, require the men to subordinate their individual wants to the common good of the group, and the effects of such disturbing stresses as combat, poor "morale," poor leadership, etc., on this group-dependence situation.

Thereafter follow chapters outlining the various types of reactions to the various forms of stress, illustrated by numerous case histories. The psychodynamics involved in these reactions is given in detail, and it is in these chapters on psychodynamics that the novice in psychiatry can come quickly to *savoir faire* and thereafter be enabled to interpret correctly the case histories for himself. Treatment is also presented in detail, and it is here that those who regard an "N-P" diagnosis as an admission of hopelessness or failure should be relieved of their pessimism.

In case after case the authors show that ventilation of suppressed feelings (abreaction) plus insight provided by the psychiatrist or gained by the patient himself in the abreaction process are often entirely sufficient to "Keep 'em flying," as was the primary tactical consideration in the zone of combat, or to rehabilitate the men into civilian life, as was their concern when working in hospitals in the United States.

In the many cases in which the patients became "blocked," i.e., unable in the conscious state to ventilate their suppressed feeling (abreact), the authors utilized the technic of narcosynthesis. This consists of injecting intravenously from 0.25 to 0.5 mg. of a 2.5 to 5 per cent solution of sodium pentothal, inducing a near sleeping state. The patient is then given a "crucial word stimulus," e.g., some reference to a harrowing experience; or is given to believe he is in flight, and the patient proceeds to reënact his experiences. This technic enables the therapists to obtain information unattainable by them in the patient's conscious state and also as a means of being sure that all pertinent suppressed material has been ventilated. The narcosynthesis procedure itself often provides the patient with sufficient insight, but more often the psychiatrist's interpretation is necessary. The authors term this process of abreaction plus insight a synthesis, that is to say, the patient is brought to understand his disturbed behavior, what caused it and how he can correct it. This in nearly all cases produces complete disappearance of symptoms. Additional psychotherapy such as encouragement, etc., further solidifies the patient in the asymptomatic state. The symptoms do not recur because the cause has been removed.

The psychiatric interview technic, with narcosynthesis when indicated (about 50 per cent of cases), was regularly highly successful in nearly all cases, including severe anxiety states, depressions and (of more general medical interests) psychosomatic states such as vomiting, diarrhea, abdominal pain, etc.

The authors point out that a great percentage of men developed symptoms after return to the United States. This evidence upsets the comfortable belief of so many that such devices as furlough, rest, home, etc., are uniformly and per se successful therapy of neuroses. "War Neuroses are Psychoneuroses," the authors point out, and the treatment is rational psychotherapy, as extensive as the therapist feels necessary, or sufficient to rehabilitate the patient in the time allotted. The time available for individual attention in the Army was often very short, and for this reason narcosynthesis was further valuable as a time-saving device.

"Men Under Stress" concludes with chapters on Applications to Civilian Psychiatry and General Social Applications. The authors make a compelling appeal for the introduction of psychiatry early in the medical school curriculum, before the student becomes swallowed up in the concepts of cellular pathology. They appeal for greater psychiatric orientation among general practitioners, the bulk of whose practice consists of psychogenic disorders.

In the discussion of the general social implications of psychiatry the reader may well be struck with a realization of the absolutely limitless applications of psychiatric knowledge. He may be convinced, as are the authors, that in no other field of medicine are the opportunities and needs for development so great as in the field of psychosomatic medicine, "wherein lies the future of medicine."

The authors present an intelligent analysis of the "predicament" of the veteran in the civilian milieu and make worthwhile suggestions for correcting the many patently wrong attitudes about veterans so commonly seen today. The reader is stimulated to concern for the correction of many prevalent and traditional attitudes in American life, fraught with immaturity and maladjustment, and to see the correlation between such attitudes and the hopes for our Nation's "adjustment" in an emotionally mature world of United Nations.

Daniel J. Sullivan, Jr.

JOHN ANDREW COLLINS, M.D.

(1877–1947)

Dr. John Andrew Collins, a staff member of Episcopal Eye, Ear and Throat Hospital, died April 9, 1947, at the home of his daughter, Mrs. Howard W. Vesey, 4915 Glenbrook Road, N.W. Dr. Collins was a specialist in ophthalmology and otolaryngology and had been associated with the Hospital since 1945, when he moved to Washington from Warren, Ohio. He affiliated with the Medical Society as an Active member the same year.

Born in St. Louis, Mo., December 11, 1877, Dr. Collins graduated from the Medical Department of Washington University in 1902 and interned at St. Louis City Hospital and the Emergency Contagion Hospital of the same city. He spent ten years in general practice at St. Jacobs, Ill., and then went to New York for postgraduate study at Bellevue Hospital and the New York Eye and Ear Infirmary. He maintained a private practice in Warren, Ohio, from 1920 until he moved to Washington in 1945.

In addition to his membership in the District Medical Society, he was a Fellow of both the American Medical Association and the American College of Surgeons, and a member of the Cleveland Ophthalmological Club. For many years he was an elder in the Warren (Ohio) First Presbyterian Church. He was a 32nd degree Mason, a Shriner, a Knights Templar, and a Rotarian.

He is survived by his wife, Mrs. Molly B. Collins, who also resides with their daughter, Mrs. Vesey, and two grandchildren.

ISIDORE M. LAVINE, LL.B., LL.M., M.D

(1904–1947)

Dr. Isidore M. Lavine, general practitioner and former Washington lawyer, died suddenly, April 5, 1947, in his office at 3824 34th Street, Mount Rainier, Md. He resided at 3215 Varnum Street, Mt. Rainier. Dr. Lavine was an Associate member of the District Medical Society.

Born in Syracuse, New York, June 20, 1904, he was the son of Rabbi and Mrs. Maurice S. Lavine, both deceased. After completing his high school work at Steelton, Pa., he came to Washington in 1922 to study law and enrolled at George Washington University Law School. He graduated in 1925 and two years later received his Master's degree. After practicing law in Washington for ten years he decided to study medicine.

He enrolled again at George Washington University, this time in the School of Medicine. Receiving his M. D. degree in 1941, he interned at Gallinger Municipal Hospital the following year. He was on the hospital staff of Prince Georges General Hospital, Cheverly, Md.

Dr. Lavine was a Fellow of the American Medical

Association and an Active member and past Secretary of the Prince Georges County Medical Society. He was a past President of the District Hebrew Beneficial Association, a member of the Jacobi Medical Society, the District Bar Association, and the B'nai B'rith.

Surviving are his wife, Mrs. Bessie B. Lavine; three children, Marilyn, Lawrence N. and Stewart; three brothers, Dr. Leonard L. Lavine and Dr. Oscar Lavine, both of Mount Rainier, and Dr. Harold H. Lavine, of Washington; three sisters, Miss Anne M. and Miss Bessie R. Lavine, both of Mount Rainier, and Miss Estelle Lavine, who is attached to the United States consulate in Vienna, Austria.

Streptomycin Therapy—Kolmer

(*Continued from page 236*)

pyocyanea, and other gram-negative bacilli, and is helpful in the treatment of acute brucellosis, bronchiectasis, cholangitis, peritonitis, hepatic abscess, acute Salmonella infections, bacillary dysentery, osteomyelitis, wounds, burns, and other infections listed in table 3, due primarily or secondarily to gram-negative bacilli

Encouraging results have also been observed in the treatment of tuberculosis in the sense that streptomycin has shown a suppressive effect in selected cases. The beneficial results, however, have not always proved lasting, and much more clinical investigation is necessary before final conclusions can be reached; certainly the compound cannot be regarded as a substitute for present methods of sanitation and surgical treatment.

Unfortunately, however, the results of streptomycin therapy in typhoid fever have been questionable and frequently disappointing, although most patients have shown improvement; intramuscular injections alone suffice, because supplementary oral administration apparently has not improved therapeutic results. Whether or not the compound will reduce mortality cannot be stated at the present time. Encouraging results have been observed in the treatment of some cases of acute brucellosis, but the results in the treatment of chronic infections have been of questionable value and largely disappointing.

As shown in table 3, streptomycin has proven ineffective in the treatment of gaseous gangrene and other clostridial infections; likewise, in the treatment of nonspecific ulcerative colitis, rheumatoid arthritis, and mycotic, rickettsial, viral and protozoan diseases.

Psychiatry in General Practice—Dub

(*Continued from page 249*)

When the patient talks enough he will eventually discover the irrationality of some of his conceptions. Then he will understand that his symptoms are the price he pays for maintaining certain unconscious attitudes. He will further reveal, through his relations with the physician, unreasonable attitudes similar to those he displays in other interpersonal relations. These contribute to his difficulties in living. Understanding them is a form of emotional understanding which is to be desired and is often accompanied by a display of emotion. Nonmedical therapists utilize these responses often with success. Mere intellectual understanding or explaining symptoms on an intellectual level is never very helpful.

The difference between sanity and insanity is only a matter of degree, as is true of somatic health and disease. Only by talking things over in detail is it possible to determine when psychiatric consultation is necessary. This is often delayed until medication alone has been without avail. Treatment of emotional disorders directed toward the relief of symptoms rather than removal of the causes is empirical but partially successful when the scope is realized. This is within the ability of the general practitioner. In disorders of emotional origin, the patient should be made to understand the use of medication as a means for relieving symptoms, rather than a cure to avoid fixating the mind on the physical symptoms, and to encourage cooperation in uncovering what is behind the symptoms. The patient should, if possible, be spared nonmedical advice, since this only engenders a form of dependency that perpetuates the problem and does not really help the patient. Consultation of the physician treating a neurotic with a psychiatrist may enable the practitioner to continue treatment with the assistance of the psychiatrist.

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900 17th Street, N.W.

Footnotes—Observer

(*Continued from page 272*)

armed forces, fathers would not have been drafted. * * * Dr. Claude W. Munger, Director of the St. Luke's Hospital in New York, was recently reported by the press to have heaped criticism on nurses for taking what he said was a "to-hell-with-patients" attitude. The occasion for this outburst was a discussion of the nursing situation at the Carolinas-Virginias Hospital Conference held at Roanoke, Virginia on April 6. Miss Edith M. Beattie, Executive Secretary of the Graduate Nurses, expressed surprise at Dr. Munger's statements. "They are not true," she said. "They are unfair and ill advised." On the other hand, Mr. Robert G. Whitton, Administrator of Alexandria Hospital and President of the Conference, stated that "What Dr. Munger said is what a lot of us have been wanting to say a long time." He expressed the view that there are many fine conscientious nurses, but that the nursing profession has lost a little bit of that "call" it formerly had.

T. W.

Washington Physicians of Yesterday—Lamb

(*Continued from page 275*)

devoted to pathology and morbid anatomy, but also covering public health, medical jurisprudence, anthropology, history, and similar subjects. He made a number of noteworthy contributions to medical history (some unpublished), the climax being the "History of the Medical Society of the District of Columbia, 1817 to 1909," published in 1909, a profusely illustrated volume of 501 pages, more than a third of which is taken up with biographical sketches and pictures of the members. This work, a rich mine of information concerning local medical history, was practically produced through the initiative and prodigious industry and personal detail work of Dr. Lamb, and will abide as a monumental testimonial of the labor and services rendered by him on behalf of the Society.

Dr. Lamb became a member of the District Medical Society in 1867 (Honorary member, 1922) and of the Medical Association in 1872. He rendered exceedingly valuable service to the Society, of which he was President in 1901. Among other things, from the great resources at his command, he made frequent and profuse exhibits of pathological material at the scientific meetings; he produced its monumental History of 1909; with great ability he edited its periodical, the *Washington Medical Annals*, from 1901 to 1920; he was active in promoting and consummating civic sanitary projects which have been of great benefit to the District, such as the purification of the water supply and the medical inspection of the public schools.

Dr. Lamb was an active and fearless worker in movements for the advancement of the welfare and interests of the colored race. He became a member of the faculty of the Howard University School of Medicine in 1873, and was its Professor of Anatomy from 1877 to 1923. He published a history of the school in 1900. In the early days the Howard School was the only medical college in the District of Columbia open to women students, and the local Women's Medical Society has expressed its appreciation of the efforts and services of Dr. Lamb in their behalf.

Dr. Lamb was also an active member of numerous other local and general organizations devoted to scientific and literary purposes. In addition to numerous elections to presidencies and other offices, he was the recipient of many honors and testimonials in recognition of his services. In personality and character he was gentle and unassuming, honest and sincere, prodigiously industrious and energetic, sympathetic and altruistic, broad-minded and cultured, a competent and esteemed teacher. His long life was one of intensive and productive activity and research, pursued unremittingly over a period of more than fifty-five years.

On May 20, 1868, he married Lizzie Scott, and from this union issued Dr. Robert Scott Lamb, well-known ophthalmologist in Washington. After the death of his first wife, he married Dr. Isabel Haslup on July 3, 1899 (born 1864, M.D. 1897, died January 18, 1936), herself a physician; she rendered her husband much assistance in his historical and literary work.

Dr. Daniel Smith Lamb died April 21, 1929. On the following May 18, a joint memorial meeting of the Medical Society and the Anthropological Society of the District of Columbia was held in his honor.

JOHN B. NICHOLS, M.D.

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RESEARCH AND TOTAL HEALTH[*]

THOMAS PARRAN, M.D., F.A.C.P., F.A.C.S.

Surgeon General of the United States Public Health Service

DR. GEORGE MARTIN KOBER was dean of the College of Medicine at Georgetown University when I was a student. Through his lectures on Hygiene to my class of 1915, I was inspired to engage in this specialty as a life work. He and his contemporary, Dr. J. J. Kinyoun, introduced me to the work of the old Hygienic Laboratory, now the National Institute of Health and research arm of the Public Health Service, and encouraged me to seek a career in "hygienic research." World War I halted my plans to become a laboratory bench worker. Compensating for personal frustration, however, I have sought with some success to give other more competent minds the opportunity of which I was deprived.

Dr. Kober was a man of many capacities; a public-spirited citizen of his community, his nation, his world; a wise leader and a devoted teacher of medicine, especially in its relation to the community it serves. I listened with interest to Kober's lectures on hygiene, and later read his published papers with avidity. As is so often the case with young men in the presence of masters, I was inclined to take him for granted. It was only after I grew older, more experienced, and, I hope, somewhat wiser, that I began to realize how substantial was the contribution he made to his time.

Let me put it in another way: Among the men who were great in medicine, when the oldest of us here tonight were fledglings, only a few, in my opinion, would be perfectly at home in a 1947 symposium on medicine and public health. Three immediately come to mind: Osler, Welch and Kober. Kober was a doctor and a hygienist ahead of his time, just as Osler was a teacher and clinician far in advance of his contemporaries, and Welch a medical sanitary statesman before his day.

In an age when almost the entire emphasis in medical research was upon the germ causation of disease, Kober's voice was one of the few urging the study of man in relation to his environment. As a military surgeon, he made a comprehensive study of the living habits, food and culture of the Indians surrounding the Army posts where he was stationed. As a professor at Georgetown, as a leader in American medicine, and in international conferences he spoke with vigor concerning clean milk for the babies of Washington; the relation of good housing to health; and the importance of ventilation and of industrial hygiene long before these subjects attracted popular interest. He was among the world leaders in the efforts of that time to control tuberculosis, a disease in which even today a large factor of recovery depends upon the patient's environment. In short, at a time when the medical world was dominated by Pasteur, Koch and Lister, viz., man versus bacterial enemies, Kober was concerned with man and his total environment, with man himself as a biologic organism, his physiology, the interaction between population groups and the industrialized, urbanized world in which man lives. In Kober's philosophy, bacteria were only one of many hazards to the health of man.

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[*] The 1947 Kober Lecture, delivered at Georgetown University, March 28, 1947.

Being ahead of his time, Kober's belief in and encouragement of medical and hygienic research was consistent and enthusiastic. Though he did not so phrase it, there is implicit in his lectures and public statements the philosophy that without such broadly based research medical teaching is sterile and the promotion of sound public hygiene impossible.

Between 1900 and 1919, the records of Congress reveal that he dealt mighty blows against the anti-vivisectionists in their perennial efforts to halt animal experimentation and thereby halt the progress of medical science. He discusses the subject further in his paper entitled "Progress in Health Conservation During the Past Fifty Years," which was published by our Service in *Public Health Reports* of April 1923. Were Kober alive today, I am convinced that he would warn us to keep constantly on the alert for renewed attacks on this sector.

The thesis that whatever contributes to length of life and diminution of disease in man is worth the life of countless animals may seem self-evident not only to men of science but to all informed persons. Nevertheless, it must be remembered that relatively few persons in the population are fully informed on this subject. Moreover, the very kindness and sentimentality of the American people, who greet medical discoveries made through animal experimentation with cries of joy, are fertile ground for the propaganda of zealots who are forever attempting to incite the indignation of Congressional and state legisators, and of their influential constituents, in the cause of preventing animal experimentation.

It is my personal opinion that the defense against such propaganda should be as persistent as the activity of its proponents, and that the best defense is a sharp offense. As things stand, nobody does anything about it until some vicious bill is introduced into the Congress or a state legislature and then the big names in medicine and research rush to the rescue—a dog is decorated to dramatize his part in winning the war. Then the whole matter is dropped until the next situation arises.

A layman who has had wide experience in public relations and is interested in this situation has suggested that one way to combat it might be through the vast mass of material on medical subjects now appearing in lay publications. Scientists whose work is interpreted by science writers should include in their material not only the effect upon human beings of their treatment or remedy but also insist that there be included in each article for the lay public a description of whatever animal experimentation preceded, as is almost universally the case, the first tests on human patients. In this way it may be possible to convey to the beneficiaries of animal experimentation, which include almost every patient of every doctor, a clearer idea of the complete dependence of the whole modern system of public health research and of therapeutics upon the free use of animals for scientific experiment.

Up to now all biologic scientists have been on the defensive in opposing legislation which would restrict the use of animals for research purposes. Though Kober is not here to lead us, I urge that those who now carry his standard in defense of animal experimentation should spearhead an attack. The objective would be positive legislation which would authorize and encourage the use of all animals and other lower forms of life for experimentation designed to ensure the survival or advance of man.

All of medicine, which is a means to health—environmental and personal—in whatever phase, be it teaching, the treatment of individual patients, or the promotion and administration of public health measures, is bound together by its dependence upon research as a foundation and in its objective, which is the fullest measure of well-being for all.

The best definition of "health" in my judgment is that contained in the Constitution of the World Health Organization: "Health is a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity." These are the terms in which Kober sought to define health, or as he called it, "hygiene."

It has been suggested to me that the most appropriate theme for my talk tonight, in view of Kober's long interest and coöperation with the official medical services of the United States Government, especially the Army Medical Corps and the Public Health Service, would be a discussion of the research program of the Public Health Service, its impact upon the national health, and its interrelationship with the common objectives of physicians everywhere.

The National Institute of Health, which is the outgrowth of the old Hygienic Laboratory where Kober worked at a bench in bacteriology and inspired beginners in research, has contributed substantially and continuously since its inception a half century ago to the terra firma of proven facts about disease, although a vast sea of ignorance surrounds that firm ground and many areas are uncharted. Time permits a mention of only a few highlights.

Among the pioneers, J. J. Kinyoun made the first bacteriologic diagnosis of cholera in the Western Hemisphere, and first recognized the presence of plague here. Henry R. Carter first described the extrinsic incubation period of yellow fever which was credited by Walter Reed with giving him the lead for his historic work proving mosquito transmission.

Many of you, of course, are familiar with the work of that scientist of great stature, Joseph Goldberger, whose discovery of the association of pellagra with diet was one of the pioneer contributions to the study of nutrition and to one form of mental illness. By using dogs in his experiments he discovered that "black tongue" in them and pellagra in humans were identical nutritional deficiencies.

Alice Evans first identified brucellosis, determined that it and Malta fever were identical, and proved that this infection and Bang's disease in cattle were caused by the same organisms. The huge program of the Department of Agriculture to clean up infected herds is based mainly upon her discovery.

The studies by Edward Francis contributed practically all of our knowledge of tularemia, bacteriologic, epidemiologic and clinical.

Stiles was the first to discover and describe hookworm disease on this continent.

That typhus fever was transmitted by rat fleas, instead of by body lice alone, was discovered by Dyer, now Director of our National Institute of Health, whose work on Q fever also is outstanding.

That the ground squirrel and other sylvatic rodents were hosts of bubonic plague was discovered by Rucker in 1909; disinfection of ships and buildings by hydrocyanic acid was developed by R. H. Creel and C. L. Williams.

Charles Armstrong, who delivered the 1942 Kober Lecture, first isolated the causative virus of epidemic encephalitis, first transmitted the poliomyelitis virus to the cotton rat, and discovered the virus of a new disease, lymphocytic choriomeningitis.

An effective vaccine against Rocky Mountain spotted fever was contributed by R. R. Spencer and his co-workers, the first vaccine against any rickettsial disease. This was followed later by the development of a vaccine against typhus fever by Cox which was used with such success by our armed forces in the War. This vaccine was further improved by Topping, who also developed a hyperimmune rabbit serum for the treatment of Rocky Mountain spotted fever, the first therapeutic agent for this disease.

Sebrell and Butler identified ariboflavinosis, a nutritional deficiency and established a specific treatment for it. Dean and co-workers demonstrated the relation of fluorides in drinking water to the incidence of dental caries, and by adding fluorine to certain municipal water supplies are testing its effect upon dental caries in whole population groups. Contributions by Hardy and Watt to the knowledge of dysentery were invaluable during the War.

Mahoney at our Staten Island Laboratory was the first to prove the effectiveness of penicillin in the treatment of syphilis. Eagle has synthesized and demonstrated in Africa the effectiveness of a new drug (P-arsenosophenylbutyric acid) in the cure of human trypanosomiasis in its early stages. Doctors at the Public Health Service Hospital at Carville, Louisiana, using other new drugs, promin, diasone, and promizole, in the treatment of patients, are recording the first apparently complete cures in the thousands of years of struggle against leprosy.

Wartime coöperative research, in which the Institute took a leading part, synthesized and tested on animals more than 12,000 potential anti-malarial drugs. One of these, chloroquine, is considered superior to quinine or atabrine in suppressing malaria attacks, while another, pentaquine, is highly effective experimentally in preventing the customary long series of relapses. Hollis and his group demonstrated the effectiveness of DDT in the eradication of malaria in civilian communities.

The development of continuous caudal analgesia by Hingson and Edwards marked a great advance in obstetrical practice. Palmer's studies on histoplasmosis have shown that tuberculosis is not the only cause of pulmonary calcification. Morgan's development of the phototimer has made mass roentgenography a practical public health tool. Marshak recently discovered a new antibiotic which is of value in tuberculosis in guinea pigs.

The control of biologic products as carried out at the Institute for the past 44 years has set the standard for the world.

As a result of industrial hygiene research at the National Institute of Health, deaths among workers handling TNT in munition plants during the last War were reduced to only 22 in contrast to the many hundreds of deaths from this cause during World War I. The toxicologic standards and methods of engineering control have been determined for a long list of dangerous chemicals developed for industrial use during the War. Studies in aviation medicine have produced important findings in regard to altitude, pressure and temperature ranges both for combat and long-range commercial flying.

At the National Cancer Institute in 1940, Lorenz and Stewart first produced experimental gastrointestinal cancer in animals. Three years later, their co-worker, Earle, first transformed normal mammalian cells, grown in test tubes as tissue cultures, into cancer cells that would invade and kill animals of the same strain from which the cells originally came. Other research accomplishments in the National Cancer Institute have shown that:

There is no single cause of cancer, and conditions which bring about cancer in one organ or tissue may bear no relationship whatever to the conditions which bring on cancer in another organ or tissue.

Certain chemical compounds are specific in their cause of cancer in selected tissues of the body.

Continued exposure to sunlight will cause skin cancer in individuals with sensitive skins.

Enzyme content and patterns of normal cells and cancer cells are different. This information may lead to development of simple diagnostic tests and simple means of treatment of cancer with chemicals.

Living cancer cells can be made in the test tube as a result of treatment of normal cells with chemicals, showing conclusively that the change from "normal" to "cancer" can occur within the cell itself.

The "milk factor" which causes cancer in mice acts in ways similar to other known infectious materials, and animals can be protected from the effect of this infectious material, which is probably a virus, by administration of an antiserum.

Pulmonary tumors in animals are governed by genetic factors.

There is an experimental method for causing stomach cancer, which kills 1 out of 5 men dying from cancer.

The "acid phosphatase" test as a diagnostic test for cancer of the prostate is specific.

The transparent window is an ideal device for use in study of reaction of normal and cancer cells in the living animals.

A polysaccharide made from certain bacteria is active as a treatment for cancer. Work continues on this and on other substances which likewise show promise of therapeutic value. In fact, a large scale interdisciplinary approach in chemotherapy to the cancer problem offers hope of developing a cancer cure or cures.

Careful surveys by the Institute staff have shown that over 3½ cases of cancer exist for every recorded death.

A nation wide study of gastric cancer has been developed through teamwork of many scientists, bringing to bear upon this major cause of cancer deaths a wide range of scientific disciplines. As a result, our ability to diagnose gastric cancer in its earlier stages has been substantially improved.

Outstanding accomplishments in outside institutions supported either in whole or in part by grants from the National Cancer Institute include:

An operation for removal of ovaries or testicles upon newborn mice which has caused cancer to develop in the adrenal gland of such animals (100 per cent) a year later. This has shown the relationship of the cancer process to that of growth and development and the influence of glandular imbalances in cancer causation.

Development of evidence showing that a restricted diet plays a definite role in the prevention of many types of cancer, including leukemia, in mice that ordinarily develop a high cancer incidence.

The development of two cyclotrons supported in part by grants from the National Cancer Institute. This instrument is playing an important role in the production of radioactive isotopes which are now being used extensively as tools for the study of normal and cancer tissues. These cyclotrons played a role in development of the atom bomb.

Proof that radioactive phosphorus is of value in treatment of certain diseases of the blood (leukemias).

Improvement in technics in the treatment of cancer of the larynx by concentrated irradiation.

Development of many additional tumor clinics by aid to the American College of Surgeons, which stimulates and develops such clinics.

The War is over though there is as yet no peace. Perhaps there will be no peace until mankind has demonstrated, and especially the United States, whose destiny appears to involve leadership of the forces of democracy against totalitarianism, that the lessons of war have been learned and that the people of the suffering nations are prepared to make democracy work.

In the sector which is of mutual interest to Georgetown Medical School, the practicing physician and the Public Health Service, the best way to make democracy work would seem to lie in the prompt application for the benefit of all the people of what research, aided by free animal experimentation, has taught us of ways and means to prevent unnecessary deaths and needless suffering and to explore purposefully the as yet unsolved factors in health and disease.

This is not a task to be accomplished successfully by any single institution, group or Federal agency. As its results should be freely available for everyone, so the successive steps in the advancement of research should win the participation of the best brains of American science, wherever situated and in whatever capacity each man and woman is able to serve. As Dr. Vannevar Bush has said, "science is a regenerative system which reveals new unknowns with every discovery made and each question answered." Since man in his present state of intellectual development can see no end to research into the mystery of life, it is imperative at this stage to develop teamwork for the common good of research rather than institutional or personal competition.

Realizing that its own scientists can attack only a fraction of the problems crying for solution, the Public Health Service with the approval of Congress for several years has been developing sound working partnerships with institutions and organizations interested in medical research. This is a fruitful field for teamwork.

A nationwide peacetime program of support for scientific research in medical and related fields, guided by more than 250 leading scientists, now operates in 21 principal areas of medical research. This program is financed by U. S. Public Health Service grants to independent scientists and institutions without any effort to place them under Government control. In addition to grants-in-aid, fellowships and traineeships are provided. Such research fellows and trainees are not obligated to enter the Public Health Service or any other Government organization upon completion of their training. Wherever they work, the Nation as a whole will benefit and the national health will be enriched. Equal independence characterizes our research grants-in-aid. The investigator may carry out his project in any way he thinks best. He is required to make only such reports as will assure us that the money which you, the taxpayers, are spending for this purpose is wisely and honestly used. Papers resulting from this work may be published at the author's election and are not subject to Government review. This particular program of the Public Health Service, in my opinion, symbolizes the American ideal of government; that is, it enhances the opportunities of the individual without hampering his scientific freedom.

Both in principle and as administered by Dr. Van Slyke, this program has been approved wholeheartedly by leaders in medical research. From its inception late in 1945 up to date, a total of 294 research projects involving $4,100,000 in grants were undertaken in 86 universities, hospitals and other public and private institutions in 31 states. New applications are being received at a rate of almost a thousand a year.

The benefits from medical research in most of which animal experimentation is essential, accrue to millions of people. Their lives are made healthier, happier and longer through widespread application of the knowledge thus gained. The National Advisory Health Council has stated: "There are few purposes for which public funds could be used more appropriately than to discover ways to prevent and cure illness and to prolong the useful years of life."

During the War it was necessary to sacrifice fundamental research in order to arrive at specific objectives promptly. Much of what is called "basic" research may not immediately appear to lend itself to clinical application. Even the great Einstein had no thought that in developing his mathematical concepts he was laying a scientific foundation for an atomic bomb. But whenever a body of facts is assembled, practical use for them will later be found. The storehouse of fundamental data from which further advances in medical science can be made needs restocking and enlargement. Curtailed during the War, the opportunity to do this is now greatly broadened.

Our research grants are additive, being intended to provide support for additional research that would not be conducted without such funds. They are not substitutive and consequently are not to be used to relieve a university or other institution of its financial responsibility for usual teaching, administrative or research functions.

Three groups have been designated by the Congress to make recommendations to the Surgeon General regarding means necessary and appropriate to carry out his responsibilities with respect to research and investigations. They are the National Advisory Health Council, the National Advisory Cancer Council, and the National Mental Health Council.

At the request of the advisory councils, their research responsibilities are divided into major categories represented by special Study Sections in which are included the Nation's leaders in medical and related sciences. They have two major functions: (1) to review applications for research grants in their respective fields, approving, disapproving, suggesting changes, and forwarding recommendations to the appropriate National Advisory Council; (2) as scientific leaders, to survey the status of research in their respective fields in order to discover neglected areas and urge competent workers to undertake research in those areas.

In terms of the Congressional authority, investigation "relating to the causes, diagnosis, treatment, control and prevention of the physical and mental diseases and impairments of man" falls within the scope of Public Health Service research and grants. Included is research in medicine, surgery, dentistry, antibiotics, bacteriology, biochemistry, nutrition, biophysics, cardiovascular diseases, endocrinology, gerontology, hematology, industrial diseases, malaria, pathology, pharmacology, physiology, neurology, psychiatry, psychology, cancer, venereal diseases, tuberculosis, tropical diseases, virus and rickettsial diseases and others—including sanitation. In this last category, Dr. Kober had an enduring interest.

Even before so many lights in Europe had gone out, the National Institute of Health was said to be the greatest single research institution in its field. In this dynamic age, when today and tomorrow may mark long steps toward the solution of some age-old problems, the Institute attempts to give financial assistance to scientists where needed, to keep in touch with all that goes forward in medical and related researches and to focus the efforts of its own workers on study of the diseases of man which presently or potentially represent major public health problems in the United States.

A foreign scientist a few months ago was a guest of the Institute and later traveled extensively about the country. His name sounded very like my own, and on several occasions when he was introduced to people who knew neither of us by sight, some confusion arose. He told me later that he had developed a stock answer: "No, I am not related to Parran but our relations are very good."

In the same sense the Public Health Service and the research scientists in institutions throughout the land are not related, but their relations are very good.

As I have indicated, studies being conducted by the Public Health Service or supported by it through grants and research fellowships cover a wide range of sciences. Much broader than "medical science" per se, the emphasis in these studies is shifting generally toward study of man himself and his reaction, physical and mental, to his total environment, not solely the study of disease-causing agents. I repeat, Kober was ahead of his time in championing this broad approach to the problems of health.

Not only is the Public Health Service concerned with research but with the better application of our present knowledge in preventing disease and in improving mental and physical health. This is done primarily through a system of grants-in-aid to the states, through the loan of technical personnel, and through demonstrations which are really "pilot plants" designed to prove the applicability of newer knowledge on a wider scale.

A sound basis of Federal-state coöperation has been developed and is being strengthened. Federal grants support, in part, the structure of state and local health services: public health nursing; sanitation; laboratory service; vital statistics; a nationwide network of rapid treatment centers for the venereal diseases in which effective treatment for syphilis is given in a period of 10 days; a program of mass radiography using the cheap microfilm method which is rapidly developing to national proportions; and prenatal and child health clinics serving a substantial proportion of the population.

State by state, surveys are being completed of the total need for hospitals, health centers and related facilities. State plans are being formulated which are designed to ensure for the whole population reasonable access to such facilities. On the basis of these plans, Federal aid is authorized to meet one third of the costs of construction up to a total of $375,000,000 over a 5-year period.

The greatest obstacles to progress toward improving the national health are first, a shortage of physical facilities, hospitals, etc., and second, a shortage of health personnel: doctors, dentists and nurses, particularly. A national policy has been formulated in the Hospital Construction Act designed to overcome, at least in part, the first of these obstacles. As yet, however, no comparable program has been developed to meet the need for personnel.

As regards medical and health personnel, the national picture is gloomy. Estimates indicate that on a basis of anticipated demands, there will be increasing shortages of all health personnel. Plans must be made now if we hope to achieve a substantial improvement within, let us say, the next decade. For example, if we are to bring the entire country up to the level of the 12 states with the highest ratios of medical personnel to population, we shall need about 270,000 physicians by 1960. This would be 95,000 more than the 1940 supply. The problem regarding dentists is even more serious. Estimates on the number of dentists required for adequate services reach 165,000. In 1940, the number of dentists was 70,000. Even if we were to limit our goal to the ratio of the 12 highest states, we would need 113,000 dentists by 1960.

In order to achieve this goal of adequacy, we would need to increase the present annual output of our medical schools by 75 per cent for a decade. We would have to increase the number of dentists in even greater proportion.

The shortage of nursing personnel likewise is of immediate concern. There are at present about 318,000 active registered professional nurses. It is estimated that current demands total at least 360,000, leaving a deficit of 42,000.

Also on the research side, the losses of war, especially in the ranks of science students drafted for combat duty, cannot be recouped overnight.

Since so many years are required for the training of doctors, dentists and scientists, and since insufficient institutions now exist to provide such training, a start should be made promptly if the shortage is to be ameliorated even by 1960.

Health is a vital national asset which needs to be conserved by national action on a broad front, supplementing state programs and individual action toward the same end. In this total effort our voluntary organizations of citizens dedicated to deal with specific hazards to health will continue to play a vital part. Our voluntary hospitals, which represent such a huge asset, not merely in physical plant but in intelligence, leadership and community good will, will continue to have an increasing role in this coöperative endeavor.

Likewise, the religious institutions, of which Georgetown University and Hospital, animated as they are by the spirit of charity best defined by Saint Paul, are outstanding examples, have a distinctive contribution to make toward improving the national health.

In my philosophy, the Federal Government has a responsibility in the whole field of health for leadership, for assistance weighted in proportion to need, for working on a partnership basis with the states and the voluntary and religious organizations toward the common goal, which is improved physical and mental health for the whole population.

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HEADACHE—MECHANISMS, DIFFERENTIAL DIAGNOSIS AND TREATMENT*

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Headache is one of the most frequent complaints dealt with by practitioners in every field of medicine. It has been estimated that up to 50 per cent of all patients will have pain or discomfort in the head as a primary or secondary symptom sometime in the course of their illness. If cognizance is also taken of the many people who regard a headache as such an integral, unalterable component of their bodily economy that they do not consider the possibility of medical alleviation, the frequency of the symptom reaches astronomical proportions.

In spite of the fact that it is so common, there is probably no medical condition which is as poorly understood or as frequently mishandled. Many physicians look upon the patient who consults them because of headache with a mixture of distaste and gloomy foreboding compounded equally of the knowledge that most cephalalgias are obscure in origin and difficult to treat. Because many headaches are not accompanied by positive findings on examination, another component of the doctor's attitude may be a partially unconscious resentment toward having to rely entirely on the subjective complaints and reactions of his patient. Again, headache is a sort of omnibus symptom, of importance to practically every specialty, and yet usually poorly taught in medical schools and poorly discussed and systematized in textbooks.

Although it is generally true that headache is difficult to diagnose and manage, it is equally true that it is a symptom of great importance. In itself often distressing and even intolerable, it may be doubly significant as a symptomatic warning of serious illness, either organic or functional. It may result from somatic disease of almost any portion of the body, especially the brain and its coverings, or it may represent the somatized expression of unresolved emotional conflicts. To properly evaluate and treat headaches requires knowledge, patience, and originality. As is true of almost no other symptom, it presents a challenge to the clinician, testing to the utmost his diagnostic acumen, his psychologic insight, and his therapeutic skills.

PATHOPHYSIOLOGY OF HEADACHE

In recent years a great deal of fundamentally important work has been done to elucidate the basic mechanisms of the pain in various types of headache. Penfield and McNaughton[1] restudied anatomically the nerve supply of the dura mater, supplementing this with observations on neurosurgical patients. They observed that the nerves containing sensory fibers end in, or close to, the walls of the meningeal vessels and sinuses. This work has been amplified and extended by Wolff and his collaborators[2(a–e)] and by Friedman, Brenner and Merritt[2(f)] in a large series of human and animal experiments and controlled clinical observations. Structures sensitive to pain were found to be (1) all the tissues covering the cranium, especially the arteries, (2) the great venous sinuses and venous tributaries from the surface of the brain, (3) parts of the basal dura, (4) the dural and cerebral arteries at the base of the brain, and (5) the fifth, ninth, and tenth cranial nerves and the upper three cervical nerves. The skull, pia-arachnoid and brain parenchyma are insensitive to pain. Stimulation of pain-sensitive intracranial structures on or above the superior surface of the tentorium results in pain in front of a line drawn vertically from the ears across the top of the head, and the pathways are mediated through the fifth nerve. Pain behind this line results from stimulation of pain-sensitive structures on or below the inferior surface of the tentorium, and the pathways for this are contained in the ninth and tenth cranial nerves and the upper three cervical nerves. The 6 basic mechanisms by which headache may arise from intracranial sources are: (1) traction and displacement of the longitudinal sinus and contributing veins, (2) traction of the middle meningeal arteries, (3) traction of the arteries of the circle of Willis and its branches, (4) direct pressure on cranial nerves five, nine, and ten, and the upper three cervical nerves, (5) inflammation in or about any of these structures, and (6) distention and dilatation of intracranial arteries.

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From extracranial sources, headache may arise from distention of arteries, chiefly branches of the external carotid, and from contraction and spasm of muscles of the scalp and neck. This latter mechanism may be associated with postural strain, reflexes from pain-sensitive nasal, paranasal and ocular structures, and especially with tension-anxiety states.

In the experimental investigations of the intimate mechanism of headache, particularly in the important group in which arterial dilatation has been found to play a decisive role, the use of histamine has been a potent weapon. Headaches produced by the intravenous injection of 0.1 c.c. doses of histamine diphosphate (1.0 mg. histamine base per c.c.) have been found to duplicate those occurring in migraine (Von Storch[3]), following head injury (Friedman and Brenner[4]), and in a group of patients suffering from headaches associated with psychoneuroses, fatigue, and various organic intracranial disorders (Friedman, Brenner, and Merritt[2(f)]). The ubiquitous action of histamine in mimicking such diverse types of headache suggests the possibility that many clinical entities may lead to headache through the release of histamine or a histamine-like substance which causes dilatation of intracranial arteries and consequent stimulation of pain-sensitive structures in or near their walls.

CLASSIFICATION OF HEADACHE

There have been numerous attempts at classifying headaches, none of which has been completely satisfactory because of the impracticability of using any single classificatory basis such as the etiologic, the pathologic, or the clinical. In such representative classifications as those of Adams,[5] or McKenzie,[6] and of Horton,[7] all of these criteria are used. However, in order to lend a degree of clarity and order to the differential diagnosis and treatment of headache, a classification scheme is essential, even though diverse standards are employed. The following classification, which is believed to include the most important types of headache, has proved to be useful.

1. Due to intracranial disease
    - (a) Meningeal irritation (meningitis, subarachnoid hemorrhage)
    - (b) Space-taking lesions (brain tumor, abscess, subdural hematoma)
    - (c) Lumbar puncture headache
2. Psychogenic
    - (a) Tension-anxiety
    - (b) Conversion hysteria

3. Post-traumatic cerebral syndrome
4. Vascular
   - (a) Migraine
   - (b) Hypertensive
   - (c) Histamine cephalalgia
   - (d) Temporal arteritis
5. Neuralgias
   - (a) Supra-orbital
   - (b) Occipital-cervical
6. Associated with diseases of ocular, nasal, and paranasal structures
7. Pyrexial and toxic.

It is important to remember in the differential diagnosis of headache that a careful and detailed history and at least a superficial exploration of the patient's personality pattern are usually more helpful than the physical or neurologic examination, which is often entirely negative. The patient should be questioned as to the duration of the headache; the type of onset, whether sudden or gradual; the constancy or intermittency of the pain; its character, whether sharp, dull, or throbbing; the influence on the headache of posture, weather, emotional tension; the presence or absence of accompanying ocular, nasal, or gastrointestinal phenomena; whether it is predominantly diurnal or nocturnal. To the experienced observer, the perfectionistic, worrisome migraine victim, the anxious, tremulous sufferer from a tension headache, and the blandly histrionic hysteric will be readily identifiable. The social and economic background which make up the life situation of the patient will frequently offer a more cogent explanation of a headache than a battery of laboratory procedures. This does not rule out, of course, the necessity for a thorough and painstaking physical and neurologic examination which will be fruitful, especially in the case of focal or diffuse intracranial disease. Palpation of the temporal arteries and of the scalp and cervical musculature, and percussion of the skull and cervical vertebrae may be revealing.

In the following table the essentials of the mechanism, differential characteristics and treatment of the principal types of headache are summarized.

1. Due to intracranial disease
   - (a) Meningeal irritation
     Mechanism—due to direct inflammatory or mechanical involvement of dural nerve endings (5, 9, 10, C_1, C_2) in neighborhood of meningeal arteries and sinuses.
     Characteristics—deep, steady, boring pain, often associated with stiff neck, may be generalized or predominantly occipital.
     Treatment—that of responsible condition such as meningitis or subarachnoid hemorrhage.
   - (b) Space-taking lesions such as brain tumor, brain abscess, subdural hematoma, intracranial aneurysm.
     Mechanism—due to traction on intracranial pain-sensitive structures, chiefly large arteries, veins, and venous sinuses and certain cranial nerves.
     Characteristics—recurrent attacks of bursting headache, worse in early morning, may or may not be localized, often associated with vomiting and signs of increased intracranial pressure, made worse by coughing, sneezing or straining.
     Treatment—elimination of causative lesion.
   - (c) Lumbar puncture headache
     Mechanism—secondary to a prolonged leakage of cerebrospinal fluid through the dural hole in the lumbar sac resulting from the needle puncture producing intracranial hypotension and consequent dilatation of and traction on pain-sensitive intracranial vascular structures.
     Characteristics—throbbing occipital pain worse in the upright position and relieved by recumbency occurring for 2 to 10 days after lumbar puncture.
     Treatment—may be prevented by use of Dattner's needle or replacement of

fluid by equal amount of salt solution or intravenous hypotonic saline. May be relieved by intravenous caffeine sodiobenzoate, ergotamine tartrate, forcing of fluids.

2. Psychogenic headache
   (a) Tension—anxiety
   Mechanism—chronic contraction of muscles of scalp and neck, especially in occipito-cervical region as a result of unrelieved emotional tension.
   Characteristics—continuous, tight, aching sensation, in occipital region radiating to temporal and frontal regions influenced by emotional tension and associated with tenderness of occipito-cervical angles and tenderness of posterior cervical muscles.
   Treatment—psychotherapy, heat and massage to cervical-occipital region.
   (b) Conversion hysteria headache
   Mechanism—a symbolic representation or condensation of an emotional conflict at the subconscious level.
   Characteristics—very variable, bandlike or crownlike pressure or boring sensation, unilateral or generalized, often long-lasting, unaffected by usual remedies, great disproportion between subjective complaints and objective evidence of pain, overt tension not marked.
   Treatment—psychotherapy.

3. Post-traumatic cerebral syndrome
   Mechanism—unclear, may represent (a) persisting and localized increase of vascular sensitivity following trauma, (b) effect of meningocortical adhesions, (c) irritation of suboccipital muscular and fibrous tissue secondary to injury of cervical vertebrae, or/and (d) same as psychogenic.
   Characteristics—typically paroxysmal, generalized or one-sided, affected by posture, exercise and excitement, associated with dizziness, irritability, difficulty in concentration and intolerance to alcohol, or may be indistinguishable from psychogenic varieties.
   Treatment—postural exercises, intravenous histamine, novocaine infiltration of trigger areas in cervico-occipital area, caffeine, benzedrine, prostigmine, air encephalography, psychotherapy.

4. Vascular
   (a) Migraine
   Mechanism—distention of cranial arteries, chiefly branches of external carotid artery preceded by vasoconstriction of the cerebral arteries.
   Characteristics—usually hemicranial throbbing pain, preceded by scotomata or other visual phenomena, duration several hours to days, often associated with nausea and vomiting.
   Treatment—ergotamine tartrate or dihydroergotamine parenterally; intravenous histamine; inhalation of oxygen; benzedrine sulfate; caffeine; potassium thiocyanate; niacin; benadryl and psychotherapy.
   (b) Hypertensive headache
   Mechanism—dilatation and distention of certain branches of external carotid artery.
   Characteristics—throbbing, usually frontal or frontotemporal, present in early morning and better later in day, made worse by coughing, sneezing, straining, associated with elevated blood pressure and fundal changes.
   Treatment—head-up bed, ergotamine, caffeine.
   (c) Histamine cephalalgia
   Mechanism—mechanical stimulation of pain-sensitive structures in or near the walls of intracranial arteries caused by distention of the relaxed walls by blood driven in under increasing pressure.
   Characteristics—unilateral headache of an hour or less duration, often beginning

suddenly at night, associated with homolateral lachrymation, rhinorrhea, and sweating, eased by erect position.
Treatment—histamine desensitization, intravenous adrenalin, head-up bed, immersion of hands in cold water.

(d) Temporal arteritis
Mechanism—inflammatory irritation of temporal arteries and periarterial tissues.
Characteristics—usually constant, felt in temporal areas, sometimes associated with pains in jaws, worse at night, constitutional signs usually present; temporal arteries become tortuous, enlarged, and prominent.
Treatment—resection of small segment of involved artery, large doses of thiamine.

5. Neuralgias

(a) Supraorbital
Mechanism—unknown, may be due to reflex vasoconstriction evoked by afferent stimuli from trigger points. Pressure on nerve or local changes in vasa nervorum are also possibilities.
Characteristics—sudden, brief, sharp, lancinating or tearing pains in eyebrow and adjacent forehead with complete freedom between attacks and absence of objective sensory changes. Associated with tenderness of supraorbital nerve in supraorbital notch.
Treatment—trichlorethylene, ferrous carbonate, nicotinic acid, novocaine and alcohol injections into supraorbital nerve, avulsion of segment of nerve, retrogasserian neurectomy.

(b) Occipito-cervical
Mechanism—same as for supraorbital, may be secondary to arthritis or caries of cervical vertebrae.
Characteristics—pain felt in cervico-occipital area radiating forward to vertex and frontal region. Associated with tenderness in lateral cervico-occipital angle and pain may be reproduced by pressure here.
Treatment—heat and massage to cervico-occipital region, novocaine and alcohol injections of trigger point, avulsion or section of greater occipital nerve, traction to head.

6. Headache associated with disease of ocular, nasal and paranasal structures.

(a) Ocular
Mechanism—irritation of conjunctival sac, abnormally sustained contraction of extra-ocular muscles, both also causing reflex contraction of the muscles of the scalp and neck.
Characteristics—pain, itching, and discomfort in and about eyes, sometimes referred to first division of the fifth nerve. Occipital headache associated with hyperopia, astigmatism, pronounced imbalance of the extraocular muscles or increased intraocular pressure.
Treatment—that of underlying condition.

(b) Of nasal and sinus origin
Mechanism—inflammatory irritation or sensitive mucosa over the turbinates, ostiums, nasofrontal ducts and superior nasal spaces.
Characteristics—dull, deep, aching, non-pulsatile pain felt usually in forehead and maxillary regions, less often in the back of the head, worse in morning (except with maxillary sinusitis which is worse in afternoon), associated with evidence of sinusitis and relieved by cocainization of nasal structures or by drainage.
Treatment—that of underlying condition, should be relieved by shrinkage or anesthetization of nasal mucosa and by drainage.

7. Pyrexial and toxic

Mechanism—distention of branches of the internal carotid, basilar and vertebral arteries at the base of the brain.

Characteristics—throbbing or dull, deep aching, generalized and made worse by bodily movement. Associated with fever or sepsis.

Treatment—that of primary condition.

HEADACHE DUE TO INTRACRANIAL DISEASE

The meningeal headache, either acute or chronic, is due to direct inflammatory or mechanical irritation of the dural nerve endings in the neighborhood of the meningeal arteries and the sinuses. The pain is constant, more or less severe, depending on the acuteness and intensity of the causative process, and of a deep, steady, boring character. It is felt at the top or front of the head if the meninges of the convexity are chiefly involved, and in the occipital or cervical region with a principally basilar or subtentorial process. Tenderness and hyperalgesia of the scalp and skull and spasm of the cervical musculature may be associated. Treatment of the headache is symptomatic with analgesics until the etiologic factor can be combated, as in the case of the bacterial meningitides, or is gradually absorbed, as in spontaneous or traumatic subarachnoid hemorrhage.

The previously commonly accepted explanation ascribing the headache occurring with space-taking intracranial lesions to the effects of increased intracranial pressure is no longer tenable in view of the work of Kunkle, Ray and Wolff.[2(e)] These workers have shown that artificial elevation of the intracranial pressure to abnormally high levels failed to produce headache in normal subjects, that in brain-tumor patients headache was as commonly associated with normal as with increased pressure, and that headache could often be produced in this group by lowering the intracranial pressure but never by elevating it. Headache in space-taking lesions is produced by traction on intracranial pain-sensitive structures, chiefly the large arteries, veins, and venous sinuses and certain cranial nerves. The traction may be local on adjacent structures or distant due to extensive displacement of the brain directly or indirectly by ventricular obstruction. The headache characteristically occurs as recurrent episodes of bursting pain usually worse in the morning and often associated with vomiting and evidences of localized neurologic dysfunction. In cases of brain tumor the headache is of considerable localizing value. Especially in the absence of papilledema, it may overlie the site of the lesion. Although frequently absent in cases of supratentorial tumor, occipital headache is almost invariably present with a posterior fossa mass. Paroxysmal headache suddenly appearing or disappearing with change of position of the head is characteristic of tumors causing a ball-valve blocking of the foramen of Munro by a tumor in the third or lateral ventricles (Harris[8]) or in the fourth ventricle (Alpers and Yaskin[9]). The treatment of headaches of this type can be symptomatic only until the lesion responsible is eradicated.

Headache following lumbar puncture may be of two sorts. The nonspecific type occurs in sensitive or emotionally unstable individuals, especially those who are apprehensive about the procedure or are the victims of misinformation about its effects. It is more likely to occur, the more dramatic the trappings, and if prolonged bed rest is insisted upon after the tap. It may persist for weeks or months. Except in the nature of its precipitating occasion this headache is indistinguishable from some of the post-traumatic headaches in which psychogenic factors are paramount.

The other type of lumbar puncture headache is a drainage headache due to prolonged leakage of cerebrospinal fluid through the dural hole in the lumbar sac with resultant intracranial hypotension and consequent dilatation of and traction on pain-sensitive intracranial vascular structures. The pain is throbbing in character, felt in the occipital region or back of the neck and is often associated with nausea and vomiting. It occurs only in the upright position, is relieved by lying down, and never lasts longer than a week to 10 days after the puncture. This headache may be prevented by the replacement of the removed fluid with an equal amount of salt solution or hypotonic saline administered intravenously (Reese and Shulak[10]). The chances of its occurrence can be minimized by the use of the needle proposed by Dattner.[11] This is a 20-bore outer needle, used to pierce the skin, containing an inner stylet pointed needle of 25-bore, which makes a small meningeal hole and thus prevents undue leakage. The lumbar puncture headache may be relieved by the use of ergotamine tartrate (Guttman[12]) administered intramuscularly in doses of 0.25 to 0.50 mg. and repeated as often as every 2 or 3 hours. Caffeine sodiobenzoate (0.5 Gm. intravenously) and repeated at 4- to 6-hour intervals may also be beneficial.

PSYCHOGENIC HEADACHES

Psychogenic factors, either by themselves or in combination with more or less important organic etiologies, are undoubtedly responsible for most headaches. In many cases, as in the tension-anxiety and hysterical headaches to be described, it is obvious that emotional conflicts at various levels of expression are responsible for the symptoms. In other instances, notably the headaches of migraine and hypertension, constitutional or hereditary factors are inextricably entwined with the psychogenic and later on with actual structural changes to produce the complicated mosaic from which the actual symptoms spring. The post-traumatic headache is another example of this class, in which elements of functional and organic pathology are present in varying degrees in almost every case. Still a third category includes many headaches facilely and erroneously imputed to such causes as sinusitis, eye strain, or constipation, on the basis of insignificant findings. The ranks of this last group are swollen because of the stigmata of weakness and degeneracy which still attach to any illness for which an adequate physical cause cannot be found. Also, some physicians will tend to reject the idea of a purely mental etiology because the manner in which emotional disturbances can produce an actual headache is imperfectly clear to them, and because if this concept is accepted, the treatment would have to follow lines which are divergent from the orthodox organic medical tradition in which most of them were trained.

In order to better understand the way in which unrelieved emotional conflict can produce head pain, it is desirable to divide the psychogenic headaches into two groups, the tension-anxiety and the conversion hysteria. Some observations of Franz Alexander[13] are useful in explaining this distinction. He has pointed out that psychosomatic symptoms in general fall into the categories of either the hysterical conversions or the vegetative neuroses. The former represents an attempt on the part of the patient to relieve an emotional tension in a symbolic manner, while in the latter the symptoms are not a substitute expression of the emotion but are the result of its normal physiologic concomitants, an anxiety equivalent. Thus, in the restless, dammed-up individual suffering from an anxiety state, part of the effect of his chronic emotional tension is to cause spasm and contraction of the cervical and scalp musculature, thus producing the usual tension-anxiety headache. In addition, the effects of tension, mediated over the vasomotor nerves, may have repercussions on the intracranial vascular structures in a manner similar to that described for the experimental histamine headache.

The difference in the pathogenesis of the anxiety and conversion headaches is mirrored to a certain degree in their manifestations. The tension-anxiety headache is usually felt as a continuous, tight, aching sensation often primarily occipito-cervical and radiating forward to the temporal and frontal regions. Tenderness to palpation of the posterior cervical musculature and of the cervico-occipital angles is found, and the patient can be observed to be objectively tense, restless and uneasy, and to display other evidences of vasomotor instability, such as rapid pulse, sweating palms, and dermographism.

The headache of conversion hysteria is extremely variable in its characteristics. It may be band-like or crown-like, sharply localized or diffuse. It is described in picturesque and vivid terminology in keeping with the frequently histrionic type of personality of the patient whose lack of objective evidence of pain is often at sharp variance with the intensity of his subjective complaints. The pain is usually constant and long-lasting and is not at all affected by ordinary remedies. In contrast to the tension headache, the hysterical cephalalgia varies little in response to external stimuli.

The therapy of the psychogenic headaches must be mainly psychologic, and to the extent that emotional factors enter into the genesis of other headaches, psychotherapy must have a corresponding importance. The distinction between the conversion and the tension headache is of therapeutic and prognostic importance. The former may be suddenly and spectacularly altered by forceful suggestion with or without hypnotic technics, or by persuasion, exhortation, or authoritarian appeals. However, the hysterical symptom is associated with basic personality defects of superficiality and shallowness which make the achievement of a therapeutic rapport difficult and the possibility of recurrence or change in the symptom picture rather likely. Especially in cases with compensation or legal facets, the factor of neurotic secondary gain may hamper therapy.

The tension anxiety headache is amenable to such measures as explanation, catharsis, advice about life situations, desensitization, and reeducation to the degree that actual reality problems are responsible for the precipitation of the anxiety state. In cases in which present problems are relatively unimportant and unconscious repression of instinctual strivings of preponderant psychodynamic importance, more laborious and time-consuming exploration and uncovering technics will be necessary. At least partial symptomatic amelioration can often be brought about by a program of physical exercise through which the effects of the dammed-up tension are drawn off and dissipated by muscular activity. Heat and light massage to the cervico-occipital musculature are sometimes helpful in relieving spasm and pain.

Post-traumatic Cerebral Syndrome

The post-traumatic cerebral syndrome, characterized by the occurrence of headache, dizziness on change of position of the head, instability and personality changes, and intolerance to alcohol after head injury is a disease state of great frequency and almost equally great obscurity. Innumerable papers have been written attempting to prove that the symptoms are either predominantly organic or psychogenic. The proponents of the latter view point to the fact that the precipitating trauma is sometimes inconsiderable, the usual absence of objective neurologic findings, the almost invariable presence of anxiety manifestations, the frequent involvement of compensation claims, and the general similarity to other traumatic neuroses. The organicists have their claim on the constancy of the symptom picture in spite of the diverse personalities involved, the presence of persistent electroencephalographic abnormalities, and the occasional finding of pneumoencephalographic changes and intellectual defect. A trend away from this "either-or" attitude is found in the excellent papers of Denny-Brown,[11] of Lewis,[15] and of Symonds,[16] all of whom emphasize that physiogenic and psychogenic factors are closely interwoven in every case and that only by careful attention to the relative importance of each can the patient be properly treated.

The headaches which are the most prominent feature of the post-concussion syndrome cannot be satisfactorily explained by any single mechanism, and the various theories advanced are not entirely satisfactory. Based on the reproduction of post-traumatic headaches by the intravenous injection of histamine, Friedman and Brenner[4] suggest that the head injury may result in persistent and localized increase of vascular sensitivity. The presence of adhesions between the dura and arachnoid has been postulated to account for the headaches (Penfield and Norcross[17]), but repeated series of pneumoencephalographic studies have failed to substantiate this except in a minority of cases. The fact that head injuries may be associated with damage to the fibrous, muscular, or skeletal tissues of the posterior cervical region is often overlooked. In these cases, trigger areas may be set up which are responsible for pain radiating forward over the head (Jones and Brown[18]). If the case is one in which psychogenic factors are dominant, the mechanism of the headache will be that described for either the tension-anxiety or the hysterical type, depending on the basic personality of the patient and his manner of reacting to a traumatic situation. The traumatic neurosis of which this type of post-traumatic syndrome is an example has been recently reviewed by Kelman.[19] He emphasized the pre-traumatic life situation of the patient who, on analysis, will frequently be found to have been failing in a desperate effort to live up to his idealized image of himself. The trauma at this point provides a socially acceptable excuse for his failure, and the perpetuation of the symptoms protects the excuse.

The headache occurring in the post-traumatic cerebral syndrome may be of almost any description. A type frequently seen in cases in which somatogenic factors are considerable is paroxysmal, lasting for a few hours or less. It is often unilateral or localized, although it may be generalized, and is made worse by exercise, excitement, and change of position. A history of antecedent head trauma and the presence of the other symptoms of the syndrome are necessary for diagnosis.

Much can be done to prevent the development of psychogenic post-traumatic symptoms by proper management during the acute stage of the injury. The physician should carefully avoid discussing the possibility of the development of sequelae, especially in emotionally unstable patients, since iatrogenic factors, as in the case of neurocirculatory asthma, can give rise to much trouble later on. Excessively prolonged bed rest is unnecessary, and by its ominous implications is psychologically dangerous. Graduated physical activity and postural exercises are useful at this stage.

After it has developed, the post-traumatic headache is sometimes extraordinarily resistant to treatment and may continue for months or years, especially if compensation is being paid. Friedman and Brenner have reported suggestively promising results in early cases with a single injection of 0.1 mg. of histamine intravenously. It would appear that courses of histamine "desensitization" may be indicated in selected cases. A combination of the cerebral vasoconstrictors, benzedrine, caffeine and ephedrine is effective in a certain proportion of cases. Malone[20] has reported beneficial effects from prostigmine administered orally and parenterally. Subarachnoid air, introduced intrathecally, or subdural air injected under pressure through a trephine at the site of maximal pain have been found to be successful by some but disappointing by others. In cases in which cervical injuries have occurred and trigger areas can be found, repeated infiltration with novocaine may serve to produce lasting relief. Psychotherapy of some type is indicated in most cases, and in many the major attack must be a psychotherapeutic one.

RECENT ADVANCES IN OBSTETRICS AND GYNECOLOGY*

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The specialty of obstetrics and gynecology is so interrelated to all phases of health and disease that practically any contribution to medical science can be applied in some way to human reproduction or to the diseases of women. This short outline will review a few of the outstanding advances which have directly influenced the practice of obstetrics and gynecology in the last decade. The bibliography contains only a limited number of references to detailed information on the subjects considered.

In no field of medicine have recent discoveries concerning blood transfusions and the Rh factor, advances in analgesia and anesthesia, refinements in antiseptics, discoveries in nutrition, isolation of hormones, and justification for chemotherapy and antibiotics become more applicable than in obstetrics and gynecology. The pregnant patient always presents emergency possibilities; the gynecologic patient frequently offers perplexing problems in endocrinology, infections, and newgrowths.

Blood Transfusions and the Rh Factor

One of the most discussed and important recent contributions to obstetric practice is the Rh factor. It is essential that the obstetrician understand certain fundamental principles of Rh incompatibility. A brief outline of present knowledge of the Rh factor in relation to blood transfusions and erythroblastosis follows:

1. In addition to a serologic test for syphilis, every prenatal patient's blood should be typed and the Rh factor determined. The physician should give the patient a written report of her blood group and Rh factor. In the average hospital the time spent in determining the blood type and Rh factor of an obstetric patient who has a sudden, profuse hemorrhage may mean the difference between life and death.

2. Every hospital should have an adequate supply of Group O Rh-negative blood available at all times for use in any emergency hemorrhage in the maternity patient whose blood type and Rh factor are unknown. In obstetric hemorrhage there is no substitute for blood transfusions. Blood plasma, glucose, and saline should be used only as temporary measures. An obstetric death due to hemorrhage can seldom be classed as an accident, but usually represents neglect by the patient, by her physician, or by the hospital administration. Certainly no patient with obstetric bleeding should be treated at home.

3. A transfusion of Rh-positive blood should never be given to any Rh-negative female patient.

4. If both parties to conception are Rh-positive or if both are Rh-negative, there will be no blood incompatibility to influence the fetus.

5. If the mother is Rh-negative and the father is Rh-positive, the potentialities for sensitization of the Rh-negative mother to Rh-positive fetal blood exist. The mother with no Rh factor may become sensitized either from transfusions of Rh-positive blood or from Rh-positive fetal blood cells from any one of her pregnancies.

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Fetal blood cells are thought to be admitted into the maternal blood stream through a break in the fetal-placental circulation. Unless sensitized to Rh-positive blood by blood transfusions prior to or during pregnancy, it is unusual for the Rh-negative mother to show any iso-immunization with her first pregnancy. In fact, many Rh-negative mothers give birth to a number of normal Rh-positive infants without ever showing any evidence of blood incompatibility.

6. However, once the Rh-negative mother has developed antibodies to Rh-positive blood, her chances of h ving a normal Rh-positive infant are poor. If her Rh-positive husband is homozygous, all infants will be Rh-positive. In the iso-immunized mother this means that her Rh-positive infant will show some degree of erythroblastosis. If the father is heterozygous, there is a 50 per cent chance of conception resulting in an Rh-negative fetus. The Rh-negative infant will not be influenced by the mother's Rh antibodies. While it is impossible to predict that the unborn infant of an Rh-incompatible couple will be Rh-negative, it is possible to determine the heterozygous characteristics of the father by testing other members of his family, particularly his children. The mother with Rh antibodies will show no change in titer throughout pregnancy to an Rh-negative fetus, whereas the titer usually changes if the fetus is Rh-positive.

7. In all Rh-negative women with Rh-positive husbands, the maternal blood should be tested for antibodies, beginning about the 24th week of pregnancy. This test should be repeated in 4 to 6 weeks. In patients who show an increasing Rh antibody titer before the 30th week of pregnancy, the fetus will usually be too affected with hemolytic disease to survive delivery at any time by any method. A diagnosis of severe erythroblastosis may be made before delivery by X-ray examination. The erythroblastotic infant assumes an erect Buddha position and shows a great deal of tissue edema. A light, halo effect is produced in utero about the fetal skull.

8. From the 30th to the 36th week of pregnancy, tests for Rh antibodies should be made at 1- or 2-week intervals. The development of Rh antibodies after the 30th week usually means that the infant can be saved by prepartum recognition and proper preparation for the probability of hemolytic disease in the newborn. These infants should be delivered with a minimum of birth trauma, and all efforts should be made to preserve a good fetal oxygen supply. Deep analgesia and anesthesia are contraindicated. It is doubtful that induction of labor or cesarean section is ever indicated before the 36th week of pregnancy and probably not before the 38th week. Cesarean section does not seem to increase the infant's chances of survival a great deal and there is no question that cesarean section increases the morbidity and mortality potentialities for the mother. The infant born of an Rh-negative mother who has shown high antibody titers should be given transfusions of Group O Rh-negative blood immediately after birth. If the infant shows marked anemia or anti-Rh antibodies, as much of its blood as possible should be replaced by transfusion.[1-5]

9. At present there is no known method of preventing Rh sensitization or of desensitizing the iso-immunized patient.

10. Unless the Rh-negative mother has shown a high antibody titer or unless she has given birth to an infant with erythroblastosis, there is no reason why she should not nurse her infant.

PRENATAL CARE AND THE TOXEMIAS OF PREGNANCY

The importance of premarital examination to determine the normality of genital structures, as well as an evaluation of general health, should be stressed for all women contemplating marriage. The patient who has severe renal disease, incapacitating heart disease, advanced tuberculosis, hereditary mental disease, or severe diabetes, should be advised of the hazards of childbirth. This does not mean that the patient with a slight heart murmur, an episode of pyelitis, or any one of a number of minor degrees of physical abnormality should be instructed never to have a child. Many marriages are handicapped by misguidance of this type. Studies in nutrition, child spacing, and the management of pregnancy complicating medical conditions point to a greater conservation of fetal as well as maternal life.[6–8]

One of the valuable recent advances in prenatal care has been the subjection of all maternity patients to roentgenograms of the chest. If discovered in early pregnancy, tuberculosis can usually be arrested, and the patient's family will be protected from the infection.

Not infrequently it is necessary to make a differential diagnosis early in pregnancy. With regard to pregnancy tests, the colostrum skin test, the prostigmine test, and the pregnandiol test do not give as accurate results as do reliable modifications of the rat test, the rabbit test, and the clawed-frog test, using either concentrated urine or blood serum.[9, 10]

Attitudes are changing toward the treatment of hyperemesis gravidarum. The days of darkened rooms, dull needles, and large stomach tubes are giving way to therapy in which the patient's fears and feelings receive careful consideration. Vomiting of pregnancy becomes pathologic when it interferes with nutrition to the point that acetone appears in the urine. This state of ketosis can usually be prevented by instructions which include an astringent mouthwash for the patient with ptyalism, frequent small feedings, and most of all by reassurance from an understanding, considerate physician. With the use of intramuscular vitamins, intravenous glucose, protein derivatives, and more careful attention to medical and psychic details, there is rarely any indication to interrupt pregnancy for hyperemesis gravidarum.

Good prenatal care, with particular attention to weight gain and sensible sodium restriction in the last half of pregnancy, remains our best insurance against toxemia. It is advisable to control the average patient's weight to a total gain of 15 to 20 pounds.[11] Restrictions should be made in fats, carbohydrates, and salt, and not in proteins. Therapy for the patient with severe toxemia of pregnancy consists of balanced medical and surgical care. As long as improvement continues with medical management consisting of bed rest, sodium restriction, sedation, and the use of ammonium chloride and magnesium sulfate, the pregnancy should be permitted to continue to its natural termination. However, if after a reasonable period of medical treatment there has been no favorable change in the symptoms of severe preëclamptic toxemia, pregnancy should be terminated in the least traumatic manner possible.[12] This is particularly advisable for the patient with preëclamptic toxemia superimposed on essential hypertension, chronic nephritis, or diabetes mellitus. A patient with severe toxemia of pregnancy tolerates trauma poorly. The choice between vaginal delivery and cesarean section will depend upon the condition of the cervix, the viability of the infant, the judgment and skill of the attending physicians.

Of the various drugs used to reduce hypertension in preëclampsia, magnesium sulfate, 20 c.c. of a 10 per cent solution given intravenously, slowly, has proved beneficial and fairly safe. Smaller doses of more concentrated magnesium sulfate given intramuscularly have the disadvantage of producing less apparent effect on the blood pressure, as well as the discomforts and dangers of local abscess formation. If the patient happens to have a reaction to magnesium sulfate, it may be counteracted by the immediate administration of calcium gluconate or calcium chloride intravenously. Favorable reports have been recorded for the use of veratrone (veratrum viride) as a method of reducing the blood pressure elevation associated with severe toxemia of pregnancy. If this powerful vasodilator is selected as a drug to reduce vascular tension, care must be exercised to see that pressures are not lowered too abruptly with resulting shock.[13]

INFECTIONS IN OBSTETRICS

As a general statement, the prevention of infection is still more important to the life and well-being of the maternity patient than all of the recently discovered antibacterial agents. Obstetric prophylaxis means guiding the patient through her pregnancy so that she comes to delivery, at term, in the best possible state of health and nutrition.

The patient who develops almost any type of infection complicating pregnancy has a much better chance for survival today than she would have had 5 or 10 years ago. Pneumonia, a particularly serious prenatal complication, can be controlled without loss of fetus or mother by sulfonamides or penicillin. The majority of urinary tract infections of pregnancy can be treated successfully with sulfonamides, penicillin, or streptomycin, depending upon the offending organism.[14]

The delivery room should be a clean area in which only those immediately concerned with the care of the patient are admitted. All personnel in the delivery room should wear clean scrub suits, caps, and masks which cover the nose as well as the mouth. Rectal and vaginal examination should be kept at a minimum necessary for proper definition of the progress of labor.

In preparation of the patient for delivery it is no longer necessary to paint or spray the vulva with irritating, alcohol-containing antiseptics. Present-day isotonic antiseptics or soap and water will render the skin of the vulva clean without the discomforts and occasional allergic reactions which some patients show to antiseptics containing alcohol, acetone, and dyes. The highly contaminated area around the urethra and clitoris is rarely properly prepared by the nurse. The obstetrician should always cleanse this area prior to delivery. Delivery should be accomplished with a minimum of trauma and blood loss. It is equally important to see that no unnecessary loss of blood or exposure to infection follows delivery.

Puerperal infections are frequently due to a multiplicity of organisms. Sulfadiazine is usually efficient in combating the mixed infections complicating abortions and the puerperium. When the predominating organisms are streptococci or staphylococci, it may be advisable to use penicillin instead of, or as well as, sulfadiazine. All sulfonamide drugs should be prescribed on a 24- to 48-hour basis with careful observation for headache, nausea, fever, injection of the sclera, or skin lesions. The patient should be checked for these reactions to sulfonamide drugs prior to renewing the order. During the course of sulfonamide therapy the urine should be alkaline and the fluid intake adequate. Injections of penicillin in isotonic saline solution are less painful when dissolved in about 2 to 3 c.c. rather than 5 to 10 c.c. of fluid. Daily or bi-daily dosage of penicillin in oil may be substituted satisfactorily for the multiple aqueous injections.

ANALGESIA AND ANESTHESIA

The most important modern trend in the relief of pain associated with childbirth has been the increasing utilization of well-qualified anesthetists. Under the influence of physiologically-minded and pharmacologically-trained anesthesiologists, careful evaluation of the drugs used for pain relief and particularly the mode of administration of these drugs has been made. As a result, there has been a trend away from large doses of depressing drugs such as the barbiturates, opiates, paraldehyde, and rectal ether. The only reason why large doses of barbituric acid derivatives and paraldehyde are tolerated by the patient in labor is that a good deal of the drug is rejected or not absorbed. As a route of administering controlled analgesia, the mouth and rectum are much less certain areas for absorption than either intramuscular or intravenous administration.

Synthetic demerol has become a rather popular and satisfactory substitute for morphine in obstetrics because of its combined analgesic and spasmolytic effect, with very little associated respiratory depression.[15] The usual dosage is 100 mg. given intramuscularly. The drug has no amnesic properties. Obstetric patients seem to show a wide variation in their therapeutic response to demerol. Alone or in combination with small doses of pentobarbital or scopolamine, demerol seems safer than morphine for the infant.

When inhalation gases are used for delivery anesthesia, it is essential that the patient's stomach be empty and that equipment be available for immediate aspiration of any material regurgitated into the oropharynx.[16] Aspiration atelectasis is one of the truly unnecessary but fairly common life-threatening complications associated with childbirth.

As a result of recent popularization of caudal anesthesia, a strong feeling in favor of the use of various types of nerve block anesthesia for the late first and second stages of labor has developed. Controlled continuous caudal and carefully-administered low spinal anesthesia have a definite place in obstetrics.[17–20] Their application depends largely upon the maternal-fetal indications for their use and the ability of the attending anesthetist or obstetrician to perform properly this type of anesthesia. In the absence of a competent anesthetist local infiltration and pudendal nerve block anesthesia are methods of producing pain relief which require no elaborate equipment and which can be given with safety and good results by the obstetrician.

Conduct of Labor

Around the beginning of this decade a wave of enthusiasm spread throughout a number of well-known maternity centers for the induction of labor in normal patients by elective rupture of the membranes.[21] The hazards of the procedure were soon apparent, but unfortunately many physicians have persisted in this practice. With artificial rupture of the membranes, prolapse of the cord is 2 to 3 times more common than in normal labors. Artificial rupture of membranes increases the incidence of infection, intracranial hemorrhage, fetal mortality, and postpartum hemorrhage.[22] Artificial rupture of the membranes should be reserved for those instances in which there is a real indication for induction of labor, such as severe toxemia of pregnancy, the occasional patient with diabetes, Rh incompatibility, postmaturity, and in marginal placenta previa. Even in these patients it is usually unwise to perforate the bag of waters unless the vertex is well engaged, the cervix is soft and more than 50 per cent effaced, the uterus is irritable, and the patient is at or near term. There are few procedures in obstetrics which can lead to more complications than premature rupture of the membranes. This is particularly true in fetal malpositions, in a patient with a thick, undilated cervix, and in the patient with an unengaged presenting part.

Intrauterine fetal infections and fetal deaths can be reduced by the use of antepartum sulfadiazine or penicillin as a prophylactic measure in all patients whose membranes rupture more than 12 hours prior to delivery. Sulfadiazine and penicillin pass through the placenta to increase the unborn infant's resistance to intrauterine infection.[23, 24]

Better methods and more widespread experience with X-ray pelvimetry have made roentgen mensuration a reliable and valuable adjunct in the conduct of labor.[25, 26]

There is a feeling among some obstetricians that time should be no factor in breech delivery or in the management of the third stage of labor. In breech delivery the fetal heart sounds and, later, actual palpation of the umbilical cord during the course of delivery are far better indicators of the need for immediate delivery than are the passing minutes on a delivery room clock.

In the conduct of the third stage of labor the placenta should be delivered immediately after its separation with as little trauma as possible.[27] If after the uterus has shown good evidence of postpartum tonicity, there is no indication of placental separation, an abnormality of the placenta should be kept in mind. If at any time after the delivery of the infant the placenta shows evidence of partial separation and cannot be expressed, it should be removed manually under the strictest antiseptic technic possible. No patient should leave the delivery room with the placenta in utero except in the very rare instance of complete placenta accreta or increta, in which there is no bleeding and in which the obstetrician has elected not to remove the uterus.

A postpartum hour of observation of the patient in the delivery room will help prevent many complications such as delayed postpartum hemorrhage and aspiration atelectasis.

In the field of operative obstetrics, extraperitoneal cesarean section by the supravesical approach is a very definite improvement over previous attempts at cesarean section without peritoneal contamination.[28–30] While there are relatively few instances in which a properly supervised pregnancy and labor should result in a degree of contamination necessitating the use of extraperitoneal cesarean section, this procedure has pointed out again the real importance in any type of cesarean section of spilling as little of the uterine contents as possible into the peritoneal cavity.

Hospital Delivery

There are approximately 3,000,000 livebirths per year in the United States. This figure does not include the estimated 750,000 mothers each year who abort or who give birth to stillborn infants. During the past 10 years the demand for hospital delivery has increased over 100 per cent. This demand, particularly in congested urban areas, has caused tremendous overcrowding of maternity facilities. It is estimated that at least 30,000 additional beds are needed in this country in order to have room for all of the patients who now deliver their babies at home.[31] Home delivery is rapidly becoming an outmoded method of managing childbirth. The majority of universities have given up home delivery as a time-consuming, expensive, and dangerous practice. It can no longer be said that a mother, and particularly her newborn infant, has a better chance for survival at home than in a clean, well-equipped maternity facility.

It is the responsibility of every community to have adequate facilities for the hospital care of maternity patients. Modern standards for obstetric care demand segregation of maternity patients, provision for small nurseries, well-planned labor rooms with nearby doctors' quarters, clean and well-lighted individual delivery rooms, and separate facilities for the care of infected mothers and babies. These facilities can be provided in the properly-planned small general hospital as well as in the larger maternity hospital.[32, 33]

Organization and education of the medical and nursing staffs of a hospital's maternity division are essential for the maintenance of good standards of maternity care.[34, 35] There is no place on any well-supervised staff for the absentee obstetrician. Unless the physician is willing to spend time with his patients, he should not assume the many responsibilities associated with proper obstetric practice.

One of the most influential factors in the recent reduction in maternal mortality in the District of Columbia has been the willingness of physicians to consult with each other on major obstetric complications. Hospital regulations which require consultations on such procedures as cesarean section, craniotomy or embryotomy, version and extraction, cervical incisions, induction of labor, the interruption of pregnancy, and the management of severe toxemia of pregnancy, of patients with hemorrhage of any type, of labors lasting more than

24 hours, and of patients with serious medical complications, such as heart disease, pneumonia, diabetes mellitus, or pyelonephritis, have brought about a large reduction in the number of injudicious obstetric operations, which carry with them such a high incidence of unnecessary morbidity and mortality. During its period of activity, the Maternal Mortality Board of the District of Columbia in its investigations of maternal deaths pointed out the need for better hospital facilities, for freer consultations between physicians caring for maternity patients, for better anesthesia, and for the more immediate and liberal use of blood transfusions in obstetric hemorrhage.

In the year 1945, 96.8 per cent of the deliveries in the District of Columbia were in hospitals. Only 4 mothers were reported to have had babies without the services of a physician. A total of 23 mothers failed to survive, giving the District of Columbia a maternal mortality rate of 10.4 per 10,000 livebirths, the lowest ever recorded for this area. Washington has become one of the safest cities in the Nation for any mother, irrespective of her economic standing or race, to have a baby.

With tremendous overcrowding of maternity facilities and with nursing shortages, it has been necessary to decrease the period of hospitalization for puerperal patients. To meet this situation physicians have encouraged their patients to leave their lying-in beds much earlier than the previous rule of 1 to 2 weeks. A large number of physicians now permit their patients to get out of bed whenever they feel like it, which usually means the second or third day after delivery. The immediate advantages of early ambulation, such as a reduction in thrombophlebitis, quicker recovery of body strength, possibly better uterine involution, and certainly a more rapid return of bowel and bladder functions to normal have become apparent. Allowing patients up early reduces nursing care, but it requires that the hospital provide more bathroom facilities for ambulatory patients. It is going to take some time to determine what influences early ambulation and rapid rehabilitation of maternity patients are going to have on genital structures in later life.

Female Genital Infections

In recent years real progress has been made in the diagnosis and treatment of infections which involve the reproductive system of the female patient. The physician must constantly remind himself that any ulcerative lesion of the vulva or cervix may be syphilis. In the female genital epithelium, ulcerations of syphilis can take many bizarre forms. When there is reasonable doubt regarding the etiology of any ulcerative lesion, it is always advisable to perform a dark field examination and to obtain blood for serologic testing. Following a diagnosis of syphilis, the next important procedure is to segregate the patient until she has been rendered non-infectious by a combination of arsenical, bismuth, and penicillin therapy. Delay in diagnosis of asymptomatic primary syphilis in the female is a highly important factor in the spread of this disease. The United States Public Health Service and local health departments have indicated by the results of their rapid treatment centers that once the disease has been diagnosed, the patient can be rendered noninfectious in a short period of time.

Since development of the sulfonamide drugs, upper genital tract infections due to the gonococcus have been reduced tremendously. With the use of sulfadiazine, and in persistent infections, penicillin, disability from acute and chronic salpingitis can be reduced immensely. However, these drugs will not protect the patient against the complications of hemorrhage, peritonitis, and intestinal adhesions which frequently follow the removal of acutely inflamed tubes. With these drugs to combat tubal infections, there is even less reason than ever before to operate on the patient with acute salpingitis.

Chancroidal infections readily respond to the local and systemic use of sulfonamide drugs.

There is no indication to cauterize chancroidal lesions with various types of caustics as was formerly done. That type of therapy simply adds pain, time, and scarring to the patient's period of recovery.

Lymphogranuloma venereum is a disease which is rather prevalent in metropolitan Washington. In the last few years improvements have been made in the materials used for diagnosis. The present-day Frei test consists of the intracutaneous injection of 0.1 c.c. of purified chick embryo propagated antigen. A positive reaction is indicated by a firm papule more than 0.5 cm. in diameter appearing 48 to 72 hours after injection. Although there is no specific treatment for lymphogranuloma venereum, the infection can be arrested in its acute phase by the use of sulfadiazine. Secondary infection frequently associated with chronic extensive ulcerative lesions of this disease can be reduced by the use of sulfonamide drugs.

Granuloma inguinale, diagnosed by biopsy findings of Donovan bodies in a fresh specimen can be cured by the intravenous use of tartar emetic or the intramuscular injection of fuadin. Investigation is under way regarding the response of this particular disease to streptomycin.

Condylomata acuminata, or venereal warts, respond very readily to the careful application of 20 per cent podophyllin in oil. The patient is instructed to wash the area thoroughly with soap and water about 12 hours after the podophyllin is applied. Treatment is repeated in 4 to 7 days.

ENDOCRINOLOGY

With the development of synthetic, less expensive endocrine preparations, a wide and unwarranted use has been made of these drugs. Experimentally and therapeutically, tremendous doses of synthetic estrogens and progesterone have been given for various indications. The wide range in recommended dosage by different investigators is evidence of a lack of information regarding the individual metabolism of these drugs. Favorable reports regarding the use of a combination of estrogen and progesterone for the prevention of abortion have been recorded. It will take additional time and experience to determine whether or not this type of substitution therapy is advantageous.

Hamblen[36] has shown that the use of small doses of diethylstilbestrol or estrone sulfate, 0.2 to 0.5 mg. daily, over a period of 20 days out of every month is the proper method of managing the vasomotor symptoms of the climacteric. It is rarely necessary to keep this treatment up more than 3 to 6 months. The large dose, 1-shot, shock therapy of estrogenic materials previously practiced by many physicians is no longer looked upon with favor. The cardinal principle of any endocrine therapy is to be sure that the patient does not have a tumor, cancer, or pathologic condition which may be obscured, confused, or distorted by the use of endocrine substances.[37, 38]

HUMAN FERTILITY

In the investigation of sterile matings, certain advances have been brought about which aid in the diagnosis and treatment of fertile couples. In addition to Huhner postcoital sperm tests, many husbands are now subjected to a complete urogenital examination with evaluation of fresh sperm specimens.[39]

Endometrial biopsies, which were formerly taken in the second half of the cycle and which occasionally caused interruption of early pregnancy, are now taken on the first or second day of menstrual bleeding. A secretory endometrium is considered evidence of cyclic ovulation.

Basal morning temperature recordings taken consistently either by mouth or per rectum may prove of some value as an indicator of ovulation. Normally, the basal temperature rises with ovulation.

The use of a precoital, isotonic, glucose-containing douche, as advocated by MacLeod and Hotchkiss,[40] may be of real value in prolonging the viability of the sperm.

Hysterosalpingography has been improved by the introduction of a new contrast medium called Visco-Rayopake. This substance is free from chemical irritation, is rapidly absorbed, and gives adequate radiopacity. Its use does not carry with it the hazards of oil embolism and intraperitoneal foreign body reaction which sometimes complicate the use of lipiodol.[41, 42]

CANCER

Knowing that genital carcinoma in the female responds best to therapy when discovered early, all methods of making an early diagnosis should be utilized. Following the extensive work of Papanicolaou on the cytology of cells passed from the uterus, cervix, and vagina, a widespread effort has been made to apply cell cytology as a screen test for the early diagnosis of cancer of the uterus and cervix.[43–46] Material is readily obtained by simple aspiration of the cervix and vaginal vault. The cells are spread on an ordinary glass slide and fixed in equal parts of 95 per cent alcohol and ether. Staining of the cells is a little more complicated and should be done by someone who knows the technic. Interpretation of the slides requires considerable experience. While cytologic evidence of abnormal cells must be regarded only as presumptive evidence of malignancy, the procedure is important in pointing out patients in whom a biopsy should be performed when there is no gross evidence of a cancer. This is particularly applicable to carcinoma of the uterine body and early cervical cancer. Recent reports all indicate that when discovered early corpus cancer can be cured by a combination of radium, X-rays, and surgery.[47–49]

In carcinoma of the cervix there has been an increasing emphasis on early diagnosis and a trend toward total abdominal hysterectomy with resection of the adnexae and lymphatics.[50–52] Return to the use of the Wertheim type of operation as a method of treating cancer of the cervix will bear careful consideration before its use is widespread, particularly by anyone other than the most experienced operator.[53, 54]

GYNECOLOGIC SURGERY

In preoperative and postoperative care, all of the recent advances in the use of blood transfusions and protein derivatives, in the maintenance of fluid and nitrogen balance, have been used in gynecology. One of the most appreciated contributions has been the use of pentothal sodium as an anesthetic agent for short operations in gynecology.

A majority of gynecologists have become more aware of the damage which can be done with deep cauterization and extensive conization of the cervix. Extensive conization is rarely indicated in the patient who is not going to be subjected to a hysterectomy or who has not passed the childbearing period. Fibrosis, stricture formation, and hemorrhage, all of which frequently accompany deep conization, should be avoided in the patient who is to continue with her menstrual cycles.

There has been a growing tendency to perform more total abdominal hysterectomies. On this subject, the gynecologist should have foreknowledge of the patient's cervical condition prior to opening the abdomen. When in doubt regarding the presence or absence of carcinoma of the cervix, the diagnosis should be made before any further therapy is carried out. If preliminary examination shows the presence of many thick adnexal adhesions and the cervix shows no evidence of malignancy, the cervical glands may be removed by cautery or conization prior to laparotomy. The surgeon can then remove the cervix if he believes it advisable, or he can leave it in if the abdominal operation becomes complicated to a point where the cervix cannot be removed with safety to the patient. The gynecologist must weigh the dangers of removal against the hazards of leaving the cervix and be guided entirely by the procedure which offers the greatest benefit to the individual concerned.

An important addition to the repair of certain types of urethral relaxation has been the introduction of the strap operation for urinary incontinence, in which abdominal fascia is transplanted to form a sling beneath the urethra. Excellent references to the technic of this operation have been contributed by Aldridge,[55] Studdiford,[56] and TeLinde.[57]

SPECIALTY EDUCATION

Progress in obstetrics and gynecology, as in other divisions of medicine, depends upon the results of scientific investigation, the distribution of newly acquired information, and the general application of accepted methods of care to the patient.

Few fields offer more opportunities for fundamental research than those associated with human reproduction. Medical schools, medical societies, hospitals, and national organizations have become increasingly interested in projects which promise to provide a better understanding of the many unsolved problems in obstetrics and gynecology.

The distribution of medical information has reached enormous proportions. Every physician has an opportunity to keep abreast of progress provided he plans a program of continuous education for himself. Whether specialist or general physician, this program should include frequent attendance at hospital staff conferences and participation in local, state, and national medical meetings. In addition, he should allot a part of his time for reading current medical literature, including popular articles on health problems. While the physician frequently will not approve of the material contained in popular articles, he must understand the subject matter and appreciate his patients' reactions to such literature.

It is as important for the specialist to maintain a continuous interest in all medical advances as it is for the general physician to know some of the technical details of obstetrics and gynecology. The specialist has a tendency to become a super-technician devoid of many of those qualities which endear the family doctor to his patients. In any program of specialty training complete health should be stressed as much as technical procedures.

The number of residencies approved by the Council on Medical Education and Hospitals of the AMA in either or both branches of our specialty has increased from 167 in 1930 to 768 in 1946.[58] Even with this number, it is possible for many more hospitals to organize their staffs and services to qualify as centers for resident training. In these times of excessive demand for resident positions care must be exercised, particularly by the more widely-known maternity centers, not to overstaff services.

It is obvious that the 2,044 physicians now registered as Board members in obstetrics and gynecology[58] can look after only a limited percentage of the Nation's obstetric patients. It has been estimated that at least 7,500 additional physicians trained in obstetrics are needed to provide specialty care for all maternity patients in this country.[31] Whether or not all patients will ever be delivered by specialists is debatable. For the present it is apparent that both post-graduate and undergraduate educational programs must give to the general physician, the intern, the student, and the nurse, the safest and most practical information possible on subjects in obstetrics and gynecology. Of this group, the general physician is most likely to be in a position of greatest undivided responsibility to the patient. If his basic training has been sound, if he has kept pace with progress, and if he has the ability to recognize early complications for which both he and his patient need specialty assistance, the general physician can conduct his work in obstetrics and gynecology with safety and satisfaction to his patients.

In summary, an increasing use of scientific research methods has been employed in the specialty; educational programs have been directed at all concerned with the health of women; new drugs, antibiotics, and blood transfusions have increased patient resistance to complications; and better hospitalization has made childbirth and surgery safer. Tremendous progress has been made and will continue to be made in obstetrics and gynecology.

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THE PLACE OF THE TUMOR SPECIALIST

CALVIN T. KLOPP, M.D.
Director, Warwick Memorial Clinic

Figures on mortality statistics in the United States have indicated for many years the growing importance of the cancer problem. Cancer advanced from ninth place among causes of death in the United States in 1900 to second place by 1933, where it has remained. Huge programs have been undertaken in the field of cancer research. These will undoubtedly yield the best results in the end but are of slight help to the cancer patient at the present time. Early diagnosis still remains the important factor in the attempt to cure patients with cancer.

It is apparent to all that any measures, now available for use in detection, diagnosis and treatment of cancer and "precancerous" lesions, should be expanded to combat this disease. It is in this field that the oncologist, or tumor specialist, must prove his place. I shall attempt to outline the position of the oncologist in relation to the problems of:

1. Cancer prevention
2. Cancer diagnosis
3. Cancer treatment
4. Cancer follow-up.

In 1930 the American Society for the Control of Cancer, following the recommendation of a committee which made a study of the best means of improving service to the cancer patient, requested the American College of Surgeons to encourage formation of cancer clinics in general hospitals in accordance with the principles of a special minimum standard. At first a large portion of the patients seen in these cancer clinics were in the far advanced stages of disease when the diagnosis was obvious, and all effort centered on treatment. As patients sought earlier advice, the diagnosis became more difficult. Finally, to carry the program to its peak, an attempt was to be made to detect cancer before there were any but superficial signs of its existence.

The pioneer work in this cancer prevention program was done in New York City at the Strang Cancer Prevention Clinic, in Philadelphia at Dr. Catharine Macfarlane's Clinic, and in Chicago at the Chicago Cancer Prevention Clinic. These clinics did not give treatment. Their one function was examination, with special emphasis on conditions which might lead to cancer. These examinations were complete, including skin, mouth, tongue, pharynx, larynx, breast, pelvis, rectum, and lymph nodes, as well as blood count, urinalysis, and a routine chest film. Whenever there was a positive finding, the subject was referred back to his physician (or to a physician of his choice) and a letter sent to the physician stating the findings and the recommendations of the clinic. No treatment was given the patient at the clinic, nor was any treatment recommended to the patient himself. The results of these examinations are similar in all clinics established so far. Taking the figures of the Philadelphia group, the following were recorded:

Consecutive subjects examined		1,065
Malignant lesions found		9
Carcinoma of the colon	1	
Carcinoma of the prostate	1	
Carcinoma of the uterine fundus	2	
Carcinoma of the cervix	1	
Carcinoma of the breast	1	
Carcinoma of the skin	1	
Carcinoma of the gall bladder	1	
Carcinoma of the peritoneum	1	
Suspected malignant lesion requiring biopsies		48
"D and C" required		16
Benign tumors		54
Papillomata	20	
Lipomata	8	
Myomata	22	
Unclassified	4	

It is apparent that about 1 in every hundred subjects examined will harbor a malignant tumor and 5 in every hundred, a benign tumor. About 5 in every hundred will present a lesion that is sufficiently suspicious to require a biopsy. These are findings in supposedly healthy persons. Many other abnormalities not related to the cancer problem were discovered.

The place for the oncologist in this type of work is two-fold:

1. To arrange such clinics to serve his community.
2. To act as consultant to these clinics on early lesions, the serious significance of which may not be apparent to the physician or surgeon who has seen only a more limited number of the myriad clinical manifestations of the cancer problem.

The organization of the clinics is not a difficult problem and is well outlined by others. It is usually only necessary to provide the incentive from the physician's point of view. The incentive from the public viewpoint is already present, as evidenced by inquiries of many patients from this local area in April, 1946. Many of these subjects had hoped to travel to Philadelphia for just such examinations, because they were not readily available here. Likewise, there is a steady stream of inquiries at the National Cancer Institute in Bethesda, Maryland, relative to obtaining these examinations in this locality. In Philadelphia, New York City and Chicago all existing facilities are filled and there are long waiting lists.

The fundamental element of the cancer prevention program is a complete, thorough physical examination and history, with careful follow-up on minimal signs and symptoms. No special equipment is necessary. It is amazing how difficult it can be for a patient to obtain such an examination. Many come to the prevention clinics as the only place they have been able to get a complete examination even on direct request. They usually say that the doctor is too busy, or interested only "in his special field."

It is an easy matter for any physician to recognize the late stages of cancer, as well as the far advanced local lesion and huge metastases. However, the seriousness or potential seriousness of many small lesions is not always too well appreciated. Here is the most important place for the tumor specialist or oncologist. He acts as consultant on the minor signs and symptoms, evaluating their importance as a source of actual or potential danger in the cancer problem.

It is immediately apparent that in order to do this he must have had wide clinical experience in all phases of the cancer program. This generally implies a training similar to that given at Memorial Hospital for the Treatment of Cancer and Allied Diseases in New York City, namely, three or four years of tumor and cancer work, including all phases of the diagnosis and treatment of cancers. The familiarity gained with all phases of the cancer problem is apparent when one considers the number of varied malignant tumors seen there in a single year, as compared with the number seen in a general hospital in a similar time.

For specific comparison, in 1 year at Memorial Hospital each of the 4 residents will be responsible for the operative care of well over 100 breast cancer cases and will see about 4 to 5 times that number. On a surgical service of a general hospital in a similar period of time a resident may be responsible for as few as a half dozen breast cancers and see no more than that number all told. A resident on a medical service may well go through the entire year without seeing a single breast cancer. An intern on a rotating internship frequently will see only a half dozen breast cancers in his entire year of internship. A medical student probably will examine only 2 or 3 breast cancers during his whole medical school curriculum, and it is not unusual for a medical student never to have examined a breast cancer during his entire 4 years.

Carcinoma of the female breast is employed as an example because it is a common form of cancer in women. If the experience of the average medical student, intern and resident is taken as similar to the examples given (although it is somewhat better in some hospitals), it is apparent that the less common types of cancer will frequently never have been seen by many young physicians in training, except on rare occasions, unless there has been some period of training in a large cancer hospital or clinic. For instance, primary carcinoma of the nasopharynx is a definite entity, runs a definite clinical course, and is not infrequent in cancer hospitals. Yet it is doubtful if the intern or resident on the average general hospital service will have seen 1 during his entire period of training; or, as is more probable, he will not have appreciated what he has seen when the characteristic syndrome is present.

The following are several examples of the value of a knowledge of the varied forms of cancer. These were not cases seen at a cancer prevention clinic, but serve to illustrate the frequency with which the importance of early symptoms of malignant disease are not appreciated. This is more often the result of insufficient emphasis on the clinical aspects of the cancer problem in the training of physicians. Had these patients been given a "cancer prevention" examination by the physicians whom they originally consulted, they would obviously not have received proper advice.

Illustrative Cases

Case 1.—J. M. S., a 25-year-old white male, first noted a black mole on his forehead in 1940. It was then the size of a pinpoint. Within a period of months it reached the size of a silver dollar. It remained that size until January, 1946, when he bumped this area and subsequently noted an ulceration of the lesion. This ulceration was treated by a doctor as an infection but failed to heal. He was then sent to a hospital where an enlarged pre-auricular node was found on the side of the lesion. This node was removed and found to show melanoma (malignant). X-ray treatments were begun, but no treatment was given to the primary area. Finally, in April he was admitted to a hospital and the pigmented area widely excised and covered with a skin graft. Since an attempt at block dissection of parotid and cervical nodes showed the tumor to extend deep to the mandible, further attempt at curative therapy was useless.

It is worth noting that this lesion had been examined by at least 16 physicians, including dermatologist, surgeons and radiologists, prior to 1946. None of these recommended any treatment despite the fact that the lesion was growing. In fact, one authority definitely recommended no treatment, since he felt that it served as a good identification mark. After the lesion had ulcerated it was seen again by at least 2 doctors, who treated it as an infection. From that time on the opinion of the other physicians who saw the lesion is not always clear. Had this young boy had this black, growing melanoma excised widely in 1940, he would probably have been cured.

Case 2.—M. R., a female aged 49, in September, 1945, noted pain in the left ear, diminished hearing in the left ear, and a painless lump in the left side of the neck. In November, 2 months after the onset of symptoms, she consulted an ear, nose and throat specialist and was told that her drum was perforated. Her symptoms persisted. In January, 1946, 4 months after the onset and 2 months after seeing the first physician, she consulted a second doctor. He informed her that her tonsils were large and should be removed. Because of certain irrelevant nonmedical factors this tonsillectomy was postponed until March, 1946, when she consulted a third physician. This was 6 months after the onset. This physician recognized the potential seriousness of the lump in her neck. He advised excision for biopsy as the only means of diagnosis. This biopsy was done and showed an epidermoid carcinoma. The primary lesion was still undetected. The family was told that the only available treatment would be narcotics at the time the pain had become sufficiently severe. The patient now developed diplopia, severe headaches, and some dysphagia. Finally, after strong insistence on the part of the family, she was brought to a cancer clinic where the expected carcinoma of the nasopharynx was found and biopsied. By this time she had bilateral metastatic neck nodes and metastatic nodules in both lung fields. Palliative treatment only could be done at this time, but it should be remembered that even in the presence of involved cervical nodes but in the absence of distal metastasis, it is possible to obtain 20 to 25 per cent 5-year cures by proper radiation in carcinoma of the nasopharynx.

In this instance it is apparent that at least 3 doctors, and probably more, recognized the abnormal clinical findings but failed to interpret them properly, purely because of lack of sufficient experience in this form of cancer.

In addition to early cancers the cancer prevention program should insure recognition of the so-called "precancerous" lesions, as it is a certainty that every precancerous lesion that is adequately treated is just as much a cancer "cure" as if the lesion already showed early malignant change. These lesions are frequently overlooked.

The most frequent "precancerous" lesions are the so-called senile keratoses, the dry, scaling, keratotic areas usually occurring on exposed areas of the skin. Perhaps the next most frequent are areas of leukoplakia within the oral cavity. Then there are the "blue-black" moles, or areas of melanosis; the areas of skin previously exposed to X-radiation, adenomata of the thyroid, papillomata and fibroadenomata of the breast, leukoplakia and kraurosis of the vulva, cervical polyps, perhaps "marked chronic cervicitis," and rectal and colon polyps. In addition, the more serious implications of other findings can be emphasized, i.e., the greater incidence of gastric carcinoma in pernicious anemia, the frequency of multiple polyps of the colon in the presence of 1 polyp, the necessity for caution in repeated X-ray therapy for benign lesion or in repeated exposure during working hours, the industrial hazards of analine dyes, the potential seriousness of small doses of arsenic over long periods of time, and the necessity for guarding against excessive sunlight when the skin is of type showing early atrophy and keratoses.

The place of the oncologist in the field of cancer diagnosis is very similar to his place in the cancer prevention program. In most instances (save for a few notable exceptions which will be taken up later) the abnormal findings will have been recognized, but their potential dangers will not have been appreciated. It is the duty of the oncologist to insist upon the study of all potential signs and symptoms of cancer, even though they may seem slight.

In a few instances it will be the duty of the oncologist to carry out certain rather simple diagnostic procedures. It is amazing how often a patient will consult a doctor for hoarseness and be treated without the doctor's having visualized his larynx with a mirror. Obviously, if the disease is self-limited, the patient is cured; if not, his chances of cure are considerably decreased. Similarly the use of a laryngeal mirror for examination of any portion of the oropharynx or nasopharynx seems to have become an art reserved for a select few, when it should be employed by every practitioner and anyone who professes to do a complete physical examination. I doubt if one intern out of 10 (save one training for EENT work) learns to use a laryngeal mirror properly. Generally speaking, examination of the uterine cervix is a more commonly employed procedure. However, there are still cases of irregular vaginal bleeding being treated by oral medication without visualization of the cervix, and many without a diagnostic curettage. The other frequently omitted procedures are the ordinary digital rectal examination and proctoscopy. The latter procedure should be learned by all interns, especially those going into general practice, and should not be delegated to a select few.

The following are a few examples to illustrate some of these points:

Case 3.—S. R., a 71-year-old male, first noted a small lump in the left side of his neck in March, 1946. This was painless. His doctor first sent him to the dentist for X-ray films of his teeth. Next, his doctor sent him to the hospital, where the lump was incised and drained. No adequate biopsy was obtained. He was then given a few X-ray treatments without a diagnosis having been established and was finally told that there was nothing more to do. By this time the mass had ulcerated through the skin and invaded the mandible. Still there was no histologic diagnosis. By the time he arrived at the clinic it was possible to do little more than establish a diagnosis of squamous carcinoma, probably primary in the submaxillary gland. The lesion by that time had invaded the base of his tongue and extended beneath the clavicle. This prevented adequate surgical treatment and possible cure which would have been possible in March, 1946. Subsequently an autopsy was performed. At the time of death there were still no metastases below the clavicle.

Case 4.—E. S. J., an 18-year-old male was examined by a group of physicians in October, 1943. A "lump" was found in the right side of his neck. It caused him no concern. He was told that it was of no importance. In the course of the next 2 years it grew slowly in size. In October, 1945 he was admitted to a hospital because of the lump in his neck. He had no other symptoms. He had a complete physical examination, chest roentgenograms, complete blood work-up, dental consultation, dental X-ray films, and nose and throat consultation. After all these studies he was discharged with the same lump and a diagnosis of chronic lymphadenitis. He was admitted to a hospital in January, 1946. At that time he was being considered as a case of Hodgkin's disease. He had 3 or 4 discrete nodes in the right jugular chain, the largest of which was 2.5 cm. in diameter. He had a nodule 2 cm. in diameter in the lower pole of the right lobe of the thyroid. A tentative diagnosis of carcinoma of the thyroid with metastases to the nodes in the right side of the neck was made. One of the nodes was excised for biopsy to prove this point. It proved to be thyroid tissue. There is some difference of opinion as to whether or not this represented a marked growth of aberrant thyroid or a low-grade carcinoma. The latter opinion has been supported by most of the pathologists who have seen the sections. However, since treatment for both types of lesion is essentially the same, in February a right hemi-thyroidectomy and right radical neck dissection were done. Numerous nodes were found to contain tumor. His convalescence was uneventful, but the ultimate outcome will not be known for many years.

It should be apparent that numerous physicians failed in this case to realize the significance of a silent cervical lymphodenopathy in a young man. Likewise, most were not familiar with the life history of thyroid cancer and failed to appreciate the fact that it can be a very slowly progressive disease even without treatment.

In the field of treatment of cancer, the oncologist is many times somewhat of an arbitratof. Under ideal circumstances, I believe it is better that a given cancer problem be handled in one or two ways:

(1) By a physician trained to treat that form of cancer by all methods available, i.e., radiation, radium therapy, surgery, etc., or

(2) By the combined effort of a group with representatives of all of these separate fields.

In most instances, the second is the workable one. The first plan can be employed only in large cancer centers or cancer clinics, but is preferable. Discussion is limited to the second plan.

It is apparent to all that every specialist will attempt to improve his methods and skills to care for a larger group of patients. When two specialists representing differing methods of treatment work on the same tumor problem there will almost always be an overlapping. This overlapping will be greater under these circumstances than if one man controls both methods. The oncologist is equipped for the latter and serves well to arbitrate the many conflicting decisions in this overlap.

In addition to arbitrating borderline types of treatment, it is frequently necessary for the oncologist to bring the newer or accepted forms of cancer treatment to his given community. This may seem an unnecessary need, but there are numerous examples of its necessity. For instance, it has been generally accepted that the best results in treatment of breast carcinoma are obtained by removal of the entire breast with axillary dissection, as is practiced in the usual radical mastectomy. This will result in 5-year cures in about 75 per cent of cases with no axillary disease and 30 per cent of cases with axillary disease. These results have not been achieved by any other method of treatment known at present. Yet it is still not unusual to see breast cancer treated by radiation alone, by local excision alone, or by simple mastectomy. All of these methods are used in good faith but have not the required follow-up studies to determine if their preference over the approved method is justified. All attempts at these methods have been discarded at large cancer centers in favor of radical mastectomy, this decision being based on adequate studies and follow-up and not on opinion alone.

Again, in the treatment field the oncologist can many times suggest small additions in treatment that are otherwise overlooked. The use of frequent mouth washes and irrigations in oral cancers often make the difference between a comfortable and a very miserable patient.

Proper attention to diet in oral cancers often makes a seemingly terminal patient able to tolerate therapeutic radiation. Proper instruction in the care of a colostomy may make a depressed, confined patient an accepted member of the community. These are examples of small details which add to the effectiveness of a cancer treatment program. They are the result of caring for and seeing cancer patients in large numbers and understanding their problems.

Again, in the field of surgery the oncologist often needs to fight against the hopeless outlook that frequently is taken. The general surgeon often does not appreciate what can be accomplished by aggressive, radical, cancer surgery, which is often the only means of cure. It is admitted that this is frequently a mutilating type of surgery, but the patient must at least be given the opportunity to choose between a certain fatal outcome and a possible cure of his disease. The following is an example:

Case 5.—A 75-year-old woman came to the clinic with a basal-cell carcinoma of the left side of her face. It began 30 years prior to entry as a small lesion at the inner canthus. She refused to consult a doctor until just prior to entry to the clinic. At that time she had some bleeding and local infection. On examination she was found to have a huge ulcerating carcinoma involving the skin of the left cheek which destroyed completely the lower eyelid and part of the upper lid, invading the orbit, the nasal cavity, the antrum and the zygoma. There was still sight in the left eye. Despite the extent of this lesion it was possible to remove it completely. This necessitated bilateral external carotid ligation, partial resection of the maxilla, exenteration of the orbit, and resection of the zygoma and a portion of the nasal bones. The defect was later partially closed by a skin graft. She is now free of disease and able to carry on her usual activities with no difficulty. She wears a small patch as a dressing and is quite content. This woman was deemed incurable by a number of physicians.

Strangely enough, the value of adequate follow-up examination of cancer patients is seldom appreciated by the doctor who treats only an occasional cancer. It has become more and more apparent as our knowledge grows that it is necessary to establish some type of base line in order to evaluate the efficacy of a given cancer treatment. The most generally accepted form of evaluation is the so-called "5-year cure." Even this must be somewhat modified in certain instances. For example, 5-year cures of mixed tumor of the parotid are of little value because the average time between treatment and recurrence is about 6 years. On the other hand, 5-year cures are a poor index of the value of treatment in lymphosarcoma, since the great majority of the cases are dead within 2 years. The effectiveness of most methods of cancer treatment can be judged by comparing the course of treated as against untreated cases, but this requires follow-up studies.

From a therapeutic point of view the follow-up examinations are even more important to the individual patient. Here again, a knowledge of the life history of varied forms of cancer is the best guide as to the nature of the follow-up required. For instance, in many cancers of the head and neck it has been the accepted treatment in many clinics to perform routine neck dissections of cervical lymph-nodes. A thorough follow-up study on these cases demonstrates that in most instances the salvage rate is just as great if neck dissections are postponed until metastatic nodes are palpable in the neck, provided frequent periodic, adequate follow-up examinations are assured.

The following are some examples of the failure to appreciate the need for these periodic checks:

Case 6.—H. C., a 55-year-old male, noted a small "pimple" on the skin of his left cheek 3½ years prior to entry to the clinic. He was told that it was a cyst. This was removed by diathermy. He was not told of its nature nor given any return appointment. Two years ago (and a year and a half after its removal) he had another cyst removed from the back of his neck. At that time the original lesion on the left cheek was again excised. Again he was told nothing of his disease and given no return appointment. Three months ago (3 years after the original treatment) he burned his face and incidentally noted a lump in the same area on the left cheek. Two weeks prior to entry a biopsy was taken which proved to be adenocystic basal-cell carcinoma. By that time the lesion had extended almost to the inner canthus of the left eye and presented a serious problem of treatment. Had this man received proper cancer treatment, any recurrence would have been discovered at an early date and been properly treated. This patient had inadequate treatment and very inadequate follow-up.

Case 7.—C. B., a 67-year-old female, developed an ulceration of the right labia early in 1945. In October, 1945 this lesion was treated by biopsy followed by electrocoagulation. The biopsy showed a squamous carcinoma. The wound healed. No inguinal adenopathy was noted. No prophylactic groin dissection was recommended. Even before all the induration had disappeared from the wound, she was allowed to go without observation for 3 months. After 3 months the wound was healed and no adenopathy was noted in the groins. Now she was allowed to go without observation for 6 months. At the end of this time a large node was found in the groin which proved to be metastatic cancer. Again the course of a type of cancer was not appreciated. If metastases occur from carcinoma of the vulva, they usually do so in the first 2 years. Hence, if there are good reasons for not doing a prophylactic groin dissection, the patient should be followed every month in order to allow for early treatment of metastases which may develop.

Case 8.—E. S., a 31-year-old mother of 2 small children, had a melanoma of the forearm removed, with axillary dissection of the lymph nodes. Following this adequate treatment she was told that she had nothing to worry about and she should see a doctor in about 6 months. As patients often do, she accepted this advice as the absolute truth. Hence, when a nodule appeared in the scar of the axillary dissection she ignored it for 3 months, until the 6-month period had elapsed. She then sought medical advice as directed. At this time she had extensive axillary recurrence, plus disease in the opposite axilla. There was no longer any possible chance of eradicating the recurrent (or residual) disease and it was quite difficult to try to explain to her husband just why she had not been told to seek examination early. Now it is probable that even under an adequate monthly follow-up schedule it would have been impossible to eradicate the recurrent disease, but she should have been given that chance.

It is obvious that the general physician is in the most favorable position to help in the control of cancer, since he is the one who has first opportunity to note precancerous lesions and to discover a cancer in its earliest stage. It is, therefore, a very important duty of the oncologist to arrange suitable educational clinics for these physicians and for medical students and young doctors in training. This is a function that must be integrated into every well organized cancer clinic, and these clinics are best organized and directed by a well-trained oncologist, although it is likely that the latter will limit his work to a subdivision of the field of diagnosis and treatment of cancer, since it is obvious that the field is too great and too diversified to be covered completely by any one man.

President's Page

MEDICINE PROGRESSES

It has been a great pleasure for me to have served as your President in the past year. Like all my predecessors, I have found it an enjoyable and most enlightening experience.

My retirement follows the Centennial Session of the American Medical Association in Atlantic City by only a few weeks. Before these lines appear, the meeting will have been held and all who have participated will have returned to their homes well satisfied that they attended a historic and a long-to-be-remembered meeting.

Personally, I am one of a large group who is very proud of the AMA's record. During the century of its existence it has done more than any other group, in this or any other country, to advance the science of medicine and to raise the standards of medical practice. Today it is without question the most important medical body in the world.

There will undoubtedly be much discussion at Atlantic City with respect to the manner in which the distribution of medical service can be improved. Unfortunately, the public has received the impression, largely due to the now famous antitrust suit, that in this respect the AMA is reactionary. In my opinion this charge has been greatly exaggerated, for the AMA has for a number of years shown itself interested in economic and social problems of medicine. This is not to say that its activities in this respect have been beyond criticism, because they have not. But neither can the Association justly be accused of a do-nothing policy.

Our Medical Society has been one of the most progressive in the Nation. This is more important than is generally recognized by the medical profession of the country. If policies were initiated or actions taken which aroused public antagonisms, irreparable harm would be done physicians everywhere.

All members should familiarize themselves with the Society's program. I urge them to read carefully the Annual Reports of Officers and Boards and A Review of Committee Activities for 1946–1947, which were mailed to the membership a few weeks ago.

Our future, in a great measure, lies in the hands of a generation of physicians who have participated in the greatest military undertaking in history. Their accomplishments reflect great credit on the medical profession. One can be sure that these men who so adequately met their responsibilities in time of war can be relied upon to give sound leadership to our medical organization. I leave my office as President with unbounded faith in these leaders of the future.

William S Herbst Jr

Editorials

HEALTH PROGRAM FOR FEDERAL EMPLOYEES*

Enactment by the 79th Congress of Public Law 658 made possible the establishment of a preventive medical program for Federal employees. Heads of departments and agencies of the Federal Government, including Government-owned and -controlled corporations, after consulting with the Public Health Service and after consideration of its recommendations, may establish employee health programs for the purpose of promoting and maintaining the physical and mental fitness of employees of the Federal Government.

For many years the Service has made studies of specific industrial and occupational hazards and has furnished professional advice, upon request, to private industry and to agencies of the Federal Government. Many industrial organizations and commercial establishments have found that employee health programs have paid dividends in increased efficiency and productivity. It is anticipated that a preventive medical program operated in the several Federal departments and agencies should prove of great value in helping employees to perform their assigned duties efficiently and economically.

The responsibility for establishing and operating the health programs of the several departments and agencies of the Federal Government has been placed in the head of each department and agency. Provision has been made in the law for the heads of departments and agencies to establish, by contract or otherwise, their health programs. This is interpreted as authorizing the heads of agencies to (1) establish and operate their own health service programs; (2) contract for the establishment and operation of their health service programs, utilizing (a) other competent Federal agencies or departments, (b) private or public organizations capable of rendering the services required; or (3) establish and operate in part their own health service programs and contract in part for the services authorized.

Public Law 658 provides that health programs shall be established only after consultation with the Public Health Service and consideration of its recommendations. Public Law 658 also provides that the Public Health Service, when requested to do so, shall review the health service programs being conducted by any department or agency under authority of this Act and shall submit appropriate comment and recommendations. On January 2, 1947, a division known as the Federal Employee Health Division was established in the Public Health Service.

The Federal Employee Health Division conducts its operations under the authorities of the Public Health Service Act, Public Law 410, and Federal Employee Health Act, Public Law 658. The Division will (1) develop policies and standards to effectuate the purposes of Public Law 658; (2) conduct studies and prepare analyses relating to employee health programs in Government; (3) provide consultative services to the heads of departments and agencies of the Federal Government, including government-owned and -controlled corporations; (4) upon proper request, review and appraise the health service programs being conducted, submitting appropriate comment and recommendations; (5) negotiate contracts with departments and agencies of the Federal Government for the operation of such programs; and (6) operate the employee health programs of the Public Health Service. Demonstrations in employee health programs may also be undertaken in accordance with Section 314(c) of the Public Health Service Act as amended.

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* This is the sixteenth in a series of guest editorials by distinguished physicians and laymen.

Public Law 658 is quoted:

AN ACT

To provide for health programs for
Government employees

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That, for the purpose of promoting and maintaining the physical and mental fitness of employees of the Federal Government, the heads of departments and agencies, including Government-owned and controlled corporations are authorized, within the limits of appropriations made available therefor, to establish by contract or otherwise, health service programs which will provide health services for employees under their respective jurisdictions: Provided, That such health service programs shall be established only after consultation with the Public Health Service and consideration of its recommendations, and only in localities where there are a sufficient number of Federal employees to warrant the provision of such services, and shall be limited to (1) treatments of on-the-job illness and dental conditions requiring emergency attention; (2) preëmployment and other examinations; (3) referral of employees to private physicians and dentists; and (4) preventive programs relating to health; Provided further, That the health program now being conducted by the Tennessee Valley Authority and by the Panama Canal and Panama Railroad Company shall not be affected by the provisions of this Act: And provided further, That such health programs as are now being conducted for other Federal employees may be continued until June 30, 1947. The Public Health Service, when requested to do so, shall review the health service programs being conducted by any department or agency under authority of this Act and shall submit appropriate comment and recommendations. Wherever the professional services of physicians are authorized to be utilized under this Act, the definition of "physician" contained in the Act of September 7, 1916, as amended (U.S.C., 1940 edition, title 5, sec. 790), shall be applicable.

Approved August 8, 1946.

John W. Cronin, M.D., F.A.C.S.
Chief, Federal Employee Health Division

SPECIALIZATION IN SURGERY

During the past decade there has been an increasing tendency for specialization in all branches of medicine. Several explanations are apparent. Medical progress has been so rapid that it has become practically impossible for a single individual to keep up to date in all recent developments. Perhaps the possibility of lucrative financial return has influenced some to enter special fields; and finally, the public has learned to think in terms of specialists and to demand them when they seek medical care.

The trend toward specialization has been particularly evident in the field of surgery. The American College of Surgeons and the Surgical Boards have maintained high standards and prescribed the minimum requirements of training for those who desire recognition as specialists. There can be no question that the activities of the various specialty boards have raised the standards of patient care.

It should be emphasized, however, that the specialty boards have made it clear that they are examining boards. The diplomates of the boards are not to be regarded as members of a union or a guild who may do surgery to the exclusion of others.

It is safe to state that personal integrity cannot be evaluated accurately by any board. The variety of cases and types of operations the surgeon undertakes are his personal problem. The size and location of each community will influence the activities of individual practices.

Few surgeons have the opportunities of self-improvement which will make it possible for them to excel in all fields of surgery. Moreover, the public has demanded selective activity, and sometimes the surgeon is labeled a goiter specialist, a rectal specialist, a stomach specialist, or some other kind of specialist, not by choice but because his work is outstanding. A broad general surgical background is essential to all surgeons.

In generations past it was easy to find a surgeon who, on the same day, would remove hemorrhoids, tonsils, gallbladder, and thyroid, perform a colon operation, operate upon a stomach, and perhaps remove a uterus for good measure. Such diversified activities are now rarely necessary or advisable.

The modern surgeon is not a manual laborer whose task ends and begins with the operation itself. Surgical diagnosis and strict attention to preoperative preparation and postoperative care have become equally important to technical ability. Button-hole incisions and slap-dash, speedy operating have been replaced by careful dissections with the emphasis on the gentle handling of tissues and not "get in and out fast."

Familiarity with physiology, bacteriology, pathology and biochemistry influences not only the preoperative and postoperative program but the conduct of the anatomic dissection. Perhaps the science of surgery is approaching the art of surgery.

Few mourn the passing of the universal specialist, but perhaps he is more desirable than the surgeon whose hands can only obey his brain in an area circumscribed by a mental-anatomic boundary.

Who then shall perform this or that operation? Where should the line of specialization be drawn?

Those who accept the grave responsibility of the care of the sick and injured should ask themselves—is there available for this problem a surgeon better qualified than I? Reference and acceptance of a patient under these circumstances will bring to the public the real benefits of specialization and none of its handicaps.

Brian Blades, M.D.

MASS X-RAY SURVEY

Whether or not the District of Columbia will be able to participate in the nationwide mass X-ray survey for the detection of tuberculosis proposed by the United States Public Health Service depends largely on whether or not the relatively small amount of $60,000 can be found to implement the Health Department's participation in the proposed survey. The United States Public Health Service has pledged itself to supply the necessary equipment and personnel to undertake the X-raying of the entire adult population of the District. The local Tuberculosis Association, in turn, has agreed that it will contribute money for the purpose of undertaking the extensive and intensive educational campaign to "sell" the idea of a chest X-ray to the population of the local community. However, in order to complete the survey it will be necessary that the Department of Health secure a substantial increase in personnel, largely clerical as well as nursing. The proposed survey is to be completed in approximately six months' time.

The budget for the Health Department unfortunately does not contain the $60,000 needed for participation in the proposed survey. The pending budget of the Health Department was made up in September of 1946 when the plan of a survey had not been presented. No additions to the pending budget can be made unless Congress is willing to add the indicated amount to the present budgetary requests of the Health Department.

As for the importance of the proposed survey, it must be admitted that the essential facts with regard to tuberculosis control will not likely be changed by the findings of the survey. That is to say, the incidence of tuberculosis among the white and non-white population of the District undoubtedly will remain in more or less the same proportion; nor does the survey propose any new forms in the treatment of tuberculosis. The importance of the survey lies in the fact that it is a means that will at long last give the Health Department definite information with regard to the unknown number of patients afflicted with tuberculosis in this community. Manifestly, no health department can hope to effectively control communicable disease without knowing where such disease exists. On the basis of the annual deaths from tuberculosis in the District of Columbia it is estimated that the total number of tuberculosis patients is somewhere between ten and twelve thousand. Of this number, approximately only one half are known as patients examined and reported by the private physician or by the physicians attached to the tuberculosis clinic of the Health Department.

Although the rate of tuberculosis deaths among the whites (28.9 per 100,000) of the District is low in comparison with the published rates in other large communities, the rate for the non-whites still stands 146.1 per 100,000, which is high. Manifestly, so long as there are in this community unrecognized and uncontrolled patients suffering from tuberculosis, the community will continue to be exposed to a spread of this infection.

Granting that here in America we have the advantage of a more ample food supply, the experience of the war-devastated world makes it quite clear that if a depression should develop in this country with health-damaging food shortages and an intensification of already notoriously inadequate housing, we too will see an increase in the incidence of tuberculosis in the local population.

As it is, tuberculosis claims approximately 50,000 deaths annually in this country, and these deaths are not the sum total of the damage that attends tuberculosis. The resource-exhausting length of the illness, the loss of earning capacity, and the fact that tuberculosis does damage essentially during the years that the patient should be most productive add enormously to the economic loss that results from this infection.

NOTE ON PENICILLIN TREATMENT OF SYPHILIS

Recently it has come to my attention that syphilis is being treated with penicillin improperly. I have seen two patients who have been treated with weekly injections of penicillin. This is much worse than giving no treatment at all, as it will almost certainly lead to resistant recurrent syphilis and may easily precipitate early neurosyphilis.

If penicillin is used at all, it must be given either every three hours in aqueous solution intramuscularly, 30,000 units without interruption until at least 3,000,000 units are administered, or 300,000 units in wax daily, also intramuscularly, until 3,000,000 units or more are given.

F. J. EICHENLAUB, M.D.

The thought underlying the proposed X-ray survey is to complete a survey of the adult population in the briefest possible time so that patients discovered to have tuberculosis in a communicable form may promptly be brought under suitable control and in that way avoid passing their infection on to others. Furthermore, it is estimated that such a survey would discover many of these infections during the incipient state. It is estimated that possibly 25 per cent of early-stage patients so discovered could be competently treated in their respective homes. This is an important factor, because there unfortunately still are too few nurses in the District's institutions to permit the reopening of nearly three hundred beds for tuberculosis in the various District Government's hospitals. Altogether, the proposed survey holds much promise for making substantial headway in the ultimate control of this infection, which so long has been the cause of untimely death and enormous economic loss. The investment is relatively small; the promise for substantial good, large indeed.

GEORGE C. RUHLAND, M.D.
Health Officer,
District of Columbia

In and Out of Focus

BY THE OBSERVER

Our Veterans Take Over It must be apparent to even casually interested members of the Medical Society that far-reaching changes are taking place within the organization. Most significant is the fact that the direction of the Society's affairs is passing from the hands of the "elder statesmen" to a younger generation. This is shown by recent elections when all the top offices went to physicians who are veterans of World War II. This is a natural development because a majority of the physicians who remained on the home front during the War were middle-aged or past.

There are many aspects of this situation which are most encouraging. Had our veterans been indifferent to their medical organization upon their return to civilian life, it would not only have seriously crippled our Society, but would have been an indication that it had failed in its responsibilities. Fortunately, it succeeded in its efforts to retain the loyalty of members who served their country so faithfully in a crisis. Those who because of age or for other reasons remained in civilian life during the War, should feel elated over this circumstance.

It is not intended to suggest that our veterans should take over to the exclusion of their colleagues who were not in the service. The veterans themselves would not want it that way. All hands are needed, as Dr. Raymond T. Holden, who will take office as the Society's President on July 1, stated in a communication sent to the membership some months ago. It will be recalled that in requesting volunteers to serve on committees he said: "I need your help; the Society needs it; medicine and the community generally need it." He was speaking not only to veterans, but to all members.

The judgment and counsel of older heads are, of course, invaluable. The Society cannot afford to dispense with their services. To do so would be shortsighted indeed. The fact remains, however, that our veterans, because of their service in time of war, and the fact that many of them are already approaching middle-age, will now be entrusted with leadership.

Theirs is a great responsibility because the postwar world is a perplexing and a difficult one. Many serious problems face medicine. These must somehow be solved. Your Observer is confident that our veteran-leaders will give a good account of themselves and our Society will go forward to greater things under their direction.

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The Diagnostic Clinic As members familiar with the Society's organization structure know, one of the subcommittees of the Committee on Medical Care is the Subcommittee on Diagnostic Clinics. A year or two ago this Subcommittee was very active. It made a study of the diagnostic clinic at Johns Hopkins Hospital, submitting its findings to the Committee. On the basis of these findings the proposal was made that the Society itself sponsor a clinic. However, the Committee finally concluded to recommend to George Washington and Georgetown University Schools of Medicine that they establish diagnostic clinics for persons of modest means. In the instance of George Washington University, the response was immediate, officials of that institution announcing shortly thereafter plans for a clinic. Georgetown University has likewise made it known that it has plans. More recently, Doctors Hospital announced that it, too, contemplates such a project. So, it would seem that it will not be too long before there will be diagnostic clinics in Washington.

In view of this situation and the fact that the Subcommittee on Diagnostic Clinics will soon become active, an article appearing in the April, 1947 *Connecticut State Medical Journal* by Dr. John C. Leonard, Associate Director of the Joseph H. Pratt Diagnostic Hospital in Boston, entitled "The Diagnostic Clinic," is of particular interest. Dr. Leonard begins his article with the familiar arguments for a clinic. He states that when diagnostic and therapeutic problems become too difficult for the general practitioner to manage, there should be a clinic to which he can refer patients for highly specialized procedures. Services rendered by such a clinic, he says, are too costly when the patient has to go to individual specialists.

"It is more and more obvious, with the passage of time," Dr. Leonard states, "that the constantly rising cost of medical diagnosis and care must be levelled off and decreased if it is to be available to any large per cent of the American people." If one excepts hospital and nursing care, high costs, he says, are due to the following factors:

> "(a) The fact that, in many instances, there is a large overhead of expensive equipment and personnel in the individual offices of numerous practitioners. The overhead must be met by charges of larger fees to the patients.
>
> "(b) The specialist charges fees which are often prohibitive to the average patient. His overhead expenses are similar to or often greater than those of the general practitioner.
>
> "(c) Much of the very expensive diagnostic and therapeutic equipment, and the space which it occupies, in the physician's office, the clinic, and the hospital, is actually in use for only a fraction—four to eight hours—of each day."

Increased costs of (a), Dr. Leonard observes, can often be reduced by groups of physicians who share a common space, diagnostic and therapeutic equipment and personnel. The group may have no central control or agreement to share expenses. On the other hand, a clinic may be conducted in a formal manner common in group practice. Increased cost of medical care due to specialists' fees (b) may be reduced or controlled by group organization. Finally, he suggests that the increased cost of medical care as affected by (c) may be reduced or controlled by efficient organization of diagnostic clinics in hospitals.

> "The community hospital is being looked upon increasingly as the expected center for the medical care of the community whether that community is a village or a city and whether the hospital is a small, non-profit hospital or a large university or teaching hospital. This is a privilege and opportunity which must not be overlooked by the medical profession, but, like all privileges, it carries a great responsibility for better and more efficient medical care of the village, city, area, or state involved. There is no reason why the community hospital cannot and should not become the diagnostic center,—diagnostic clinic, if you will—for the area which it serves. Young men in their training period (interns, assistant residents and residents) could be expected to take the medical history and perform the initial physical examination under the supervision of more mature physicians. The Diagnostic Clinic thus becomes the center for the better training of young physicians as well as a reduced cost diagnostic boon for the average patient. Here, also, the younger men in medicine may become immediately productive, both medically and financially, rather than undergoing that long period of demoralizing inactivity that so frequently follows the period of hospital training while the young physician is establishing his practice. These young men should be paid $5 or $10, or more, per session or per unit of work involved.
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> "In such a system there must be a group of highly trained specialists, members of the various American Boards of Specialists or their equivalents, who are willing to serve in the capacity of consultants for a reasonable fee. If specialists are willing to be assigned to the Diagnostic Clinic on a regularly specified time and appointment system, obvious inactivity and waste of time can be easily avoided."
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> "Much of present-day diagnostic work is carried out in hospitals where patients are admitted to the hospital, and therefore occupy a hospital bed for three to twenty-one days while their diagnosis is being established. Careful study will disclose that a surprisingly large number of these patients are really not 'bed patients' but often needlessly occupy hospital beds because the Blue Cross plan and many other hospital insurance plans will meet all or a part of their expenses only if they are actually admitted to the hospital as an in-patient, i.e., a bed patient. Thus, this large group of patients occupies, needlessly, the expensive twenty-four coverage

of the hotel and nursing services of the hospital and there are, as a result, many fewer beds available for patients whose diagnosis and therapy cannot be carried out other than in the hospital. This obviously expensive and inefficient plan should be changed. Such a change is possible if the Blue Cross and other hospital insurance plans will expand their policies to cover at least a reasonable share of ambulatory diagnostic cost. It is recognized that there would still exist an abuse of in-patient versus out-patient insurance plans unless a reward system could be used. This might function as follows. All professional and service charges for the ambulatory patient might be met by the Blue Cross or other insurance plans, while, if it were necessary for the patient to be admitted as an in-patient, only charges such as the service and professional charges would be met, the remaining or purely hotel charges being paid by the in-patient. Such a plan, or a modification thereof, would offer very practical and financial encouragement for a more practicable, quantitative, and less expensive volume of ambulatory patient coverage and would, by the recognition of and charging for the purely hotel part of the expense, discourage the unnecessary use of hospital beds by patients who do not actually need such twenty-four hour care and coverage. It would be necessary, if such a plan could be worked out, for Blue Cross and other insurance plans to recognize and finance diagnostic coverage only in those clinics and centers of good medical standing, rather than in carelessly organized self-styled clinics."

There follows a discussion of charges for services rendered by such a clinic. Dr. Leonard says that charges vary considerably. The charity or very low income patient is usually charged nothing or pays no more than $2 per visit. Clinics which provide services to this group are of necessity supported by private charities, industry, and Community Chests, or the local, state or Federal Government. Fees for the individual who can pay part or all of the cost of a diagnostic workup range from $25 to $100 for ambulatory service, and $75 to $250 for in-patient diagnostic service.

"The purely diagnostic clinic," Dr. Leonard concludes, "has as its goal the establishment of the diagnosis and carries out no therapy or, at least, not more therapy than is required to assist in establishing the diagnosis. There are only a few purely diagnostic clinics in this country at the present time, of which the Pratt Diagnostic Clinic in Boston is one example. The Pratt Diagnostic Clinic, for example, accepts only such patients as are referred by a physician. This plan has several important aspects which strengthen patient-physician relationship and also make for better patient follow-up and care. By taking only patients referred by a physician, these patients can then be referred back to the local family physician with the diagnosis and a suggested plan of therapy. Too often when any clinic attempts to carry out the follow-up treatment of an out-of-town patient, a serious additional economic burden is placed upon the patient because of travel expense, hotel bills, etc. If the clinic accepts the follow-up care of the patient, the assumption is frequently made that only in the town or city where the clinic is located can therapy be carried out! In the majority of cases such an assumption is fallacious. The clinic is not usually able to carry out emergency care, if and when unforeseen complications arise out of clinic hours. There are many adequate reasons why the patient should have his local or family physician to whom he can turn in both the emergency situation and the routine carrying out of the designated therapeutic procedure and follow-up. True, the major specialty and surgical procedures such as brain and chest surgery, for example, should only be performed where there are adequately trained specialists, but the great majority of the recommended procedures can and should be carried out in the community hospital or the community from which the patient was referred for diagnosis. . . .

"Another important reason for insisting that a physician refer patients is the avoidance of unnecessary medical shopping by patients, from clinic to clinic, at a tremendous additional cost in money and an overlapping of medical effort. These 'shopper' patients all too frequently have no family physician or medical guide as a result of their having constantly moved from physician to physician and from one clinic to another, never remaining under one medical guide long enough to receive benefit from either diagnostic studies or follow-up therapy. This is most often true of that very large group of psychoneurotic patients.

"Insistence upon referral by a physician, preferably the family physician, also provides an excellent opportunity for the physician to be brought up-to-date medically by the detailed report of diagnosis and the suggested plan of therapy. If each record is complete and thorough in unfolding the diagnosis and explaining the necessary therapeutic steps, it has tremendous value as a form of postgraduate medical education for the referring physician, whether he is located in a distant rural area, a nearby town, or in the same city.

"It should be remembered that the ills of approximately 85 per cent of patients can be adequately treated by the family physician and that of the remaining 15, 10 to 14 can receive the necessary additional care in the local community hospital. This, obviously, leaves only 1 to 5 per cent of patients who may truly need the services available alone in the large hospital or medical center with its staff of highly trained specialists. It is quite idealistic, and perhaps unrealistic, to expect that only those people will come, or be referred, to the Diagnostic Clinic or large teaching hospital who really need the services which are available in such places alone. Unfortunately, human nature is such that 'the grass on the other side of the fence appears greener' and expensive medical care can always be expected to attract a certain number of medical shoppers from a great distance! This is also frequently true of the family of the patient who has been given a hopeless prognosis, by a small or a large community hospital, and who take the patient from one medical center to another in a vain quest for a cure."

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If the People Understand

The program of the Michigan State Medical Society is just about the most ambitious and varied of any medical organization in the country. Credit for the Society's outstanding accomplishments must to a considerable degree go to its able leaders. However, one should not minimize the support given by the rank-and-file of the membership. Few medical societies can boast of such unanimity and enthusiasm.

One of the Society's most costly ventures is its lay educational program. Large sums have been expended on radio broadcasts which blanket the entire state. Carefully prepared news releases are widely distributed, not only to the metropolitan, but the rural press. Speakers, too, are provided lay audiences wherever there is a demand. Most progressive and well-organized medical societies have a similar program, but not on the scale which exists in Michigan.

Such an organization inevitably is a factor in public affairs. This was made clear last February when Michigan's Governor Kim Sigler addressed the Michigan Foundation for Medical and Health Education at Detroit. The subject of his address was "The Physician and the State." In the course of his remarks he said:

"In my mind the people who should determine the state's interest in medicine are those people who are qualified to judge—not some politician, not some writer. The judges should be yourselves. You should be able to say how much the state should do. Nobody wants to see the state practice medicine.

"In the main, I am definitely opposed to socialized medicine; just as I would be opposed to the regimentation of the legal profession. You, who are experts on the subject, should be the ones to tell it fairly, frankly, honestly, and see that the people understand the need and facts and act accordingly. This is what I am going to do.

"I have a surprise for you. I believe in dealing with all these matters in a very practical manner. Mr. Richards, Manager of WJR, together with powerful stations in Cleveland and Los Angeles, told me, 'Listen, if you are really going to do all the things you say, I am going to offer you my microphone, on your desk, to tell the people in the state what you are doing.' I said, 'All right, let's try it.' After we had it started, another station came along and offered me another setup. I now broadcast from the Governor's Office every other Saturday night. . . .

"Last night I asked Dr. Hannah, President of Michigan State College, to come to my office so that we could tell the people about problems of that college—large enrollment, large number of married students, 1,500 babies. The average person has no conception of its problems.

"I want to offer you an opportunity to let the people of Michigan know what you are doing and let the people know what should be done on the subject of medical health and education. . . .

"What does the average person of Michigan know about socialized medicine? It sounds good. They believe doctors are against it because they are selfish. I know that is ridiculous, silly. I know that from various angles. The same misinformation exists about lawyers, too. For instance, recently someone asked me, 'Why don't you do something about all those persons executing deeds, the notary public who handles thousands of dollars of the life savings for people?' The criticism was that the lawyers are trying to corral all the business. However, the greatest business comes when a lawyer draws up the wrong kind of deed! If the people just fully understand, they will always arrive at the right results. I have great confidence in the average citizen when he knows the facts but I have little confidence if he does not know the facts."

No doubt the medical profession of Michigan has already taken full advantage of the opportunity offered by the Governor.

The Nursing Situation It was thought that the panel discussion on the nursing situation in the District of Columbia, presented at the Annual Business Meeting of the Society on May 7, would attract a capacity audience. Officers of the Society had been informed that many physicians wished to be heard and would be on hand to have their say. As it turned out, only a fair number were sufficiently concerned to put in an appearance. Nevertheless, those present were deeply interested and listened closely to the speakers, Dr. James A. Crabtree, Deputy Surgeon General of the United States Public Health Service; Dr. James A. Gannon; and Miss Elizabeth Earle, a member of the Nurses' Examining Board for the District of Columbia. Only Dr. Gannon had prepared a manuscript. His paper will be published in an early issue of the ANNALS.

All those who took part in the discussion agreed that the nursing problem is most complex and difficult of solution. There were several suggestions made, but no general agreement with respect to most of them. All agreed, however, on the need for practical nurses. There was a divergence of opinion as to supervision and licensure.

Dr. Gannon spoke highly of the graduate nurses, but believed that a shorter course is desirable for those who intend to do bedside nursing. He emphasized that nurses, graduate or practical, should be adequately paid. Generally speaking, his views coincide with those of the American Surgical Association. The Association recently observed:

> "Eighty-four per cent of the surgeons felt that 'nurses' aides,' equal in experience to those volunteers in wartime, and practical nurses, under the supervision of a nurse with three-year training in charge of the ward, would provide a satisfactory solution of our nursing needs. There was almost complete unanimity in the feeling of the surgical profession that the increase in the required training for nurses beyond the three-year level had not improved their ability to care for the sick and that it had not promoted closer coöperation between doctor and nurse in the care of the sick. . . ."

The Association was critical of the nursing profession, stating its position as follows:

> "Regarding help available for bedside nursing, it is notable that the American Medical Association's annual report of 1946 states that there were in registered hospitals some 80,000 practical attendants, not including orderlies and ward maids. There are now fifty schools of practical nursing approved either by the State Board of Nurse Examiners in states with legal control of the practice of the group or by the National Association of Practical Nurses' Education in states without a licensing law.
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> "The nursing profession has not utilized this help. A closed-shop practice has prevailed widely and practical nurses have not been and are not allowed in many hospitals. Their assistance to the sick has been denied. As noted, there has been expression of opposition to the training of bedside nurses in shortened courses in our leading nursing schools. In some states it is prevented by law. While this has been the attitude of their central bodies, there is by no means general agreement in the nursing profession. Shortened courses have been recommended by experienced superintendents of nursing schools. . . .
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> "The need for 'bedside' nurses at a reduced cost to the patient can be met at least in part by establishing one-year courses of training. It is essential that the medical profession itself interest itself to the extent of insisting on their establishment. The training will of necessity be given under the immediate supervision of the nursing schools. It cannot be expected to operate effectively or fulfil its purpose without the supervision and direction of the medical staff."

A correspondent who signed himself "A Surgeon" wrote a letter on the nursing shortage which was published in the *Evening Star* on April 24. He vigorously defends graduate nurses in the following language:

> "The nursing shortage is due to the increasing disparity between the great cost in time, money and labor required in becoming a nurse and the low stipend received for continued hard work after graduation. The salaries are very low in comparison with stenographers, etc., who have little instruction after leaving high school and whose jobs as a whole are easier physically and mentally. The disparity has been the same in the teaching profession, which finally is resorting to strikes to gain its proper place in the scheme of things. The nursing profession has a higher sense of duty and

responsibility to the public than almost any other, hence it has not resorted to this successful method of gaining its ends. Now it is to be rewarded by a grateful public and the editors of *The Star* with competition from hordes of poorly trained girls called 'practical nurses' who are said to be needed in this 'emergency.'

"This flight into mediocrity is easy to fathom. Hospitals are having to pay unskilled labor, maids and orderlies high wages or they quit and go to work in restaurants, on road gangs and any places needing brawn. Hospitalization insurance firms, striving to make their policies attractive through low premiums, allow insufficient funds for the hospitals to provide the care expected. Charity cases and reduced fees to the indigent further harass budgets. The hospitals are hard pressed and the economy needed to make ends meet comes from the nurses' low rate of pay.

"Then, to top it off, it is considered by the American College of Surgeons, *The Star*, Commissioner Mason, and I trust no one else, that the answer is the supplying of droves of cheap labor in the guise of the innocent student practical nurses. They will be paid so they will enroll, they will be dressed in the costumes of bona fide nurses so that they will endure the experience, and they will be graduated after learning what the maids and orderlies already know. In the meantime they will supply hired hands for the hospitals at a negligible cost compared with the modest outlay necessary for raising nurses' salaries. After graduation they will be neither flesh, fowl nor good red herring, in that they will not be allowed (and Heaven help us if it turns out otherwise!) to handle medicines, give hypodermic and intravenous medications, nor assist at operations.

"The worst result of this policy, however, is the discouragement engendered in girls who would otherwise be candidates for regular nursing school. To go through three years of rugged schooling, often after two or more years of college preparation, and find on graduation that you are doing work of much greater responsibility, yet your pay is a dollar or two more a day than that of the practical nurse one year out of high school, would certainly deter the majority of girls anxious to make something of themselves in life.

"Nursing is an honored profession in the United States where standards of training have been raised gradually in succeeding decades to the point where one can truthfully say ours are, as a whole, the finest nurses in the world. . . ."

As your Observer read the foregoing statements, he thought of a number of things. First of all, he agrees that nurses must be paid adequately. On the other hand, an increase in nurses' pay places a heavier financial burden on already overburdened patients. In an acute illness, such as a serious operative case, it might well be that special nurses would have to be employed around the clock. This would mean that at least three nurses, working eight-hour shifts, would have to be paid $10.00 each, or a total of $30.00 a day. Add to this the cost of a hospital room, the laboratory procedures required, and finally, the fees for physician's services, and one can readily see that no person of modest means could possibly afford such care.

The point which your Observer wishes to make is that nurses do need more compensation, but some way must be found to make it possible for the patient to pay for all health services. The only solution satisfactory to professional groups is the application of the voluntary prepayment method. The alternative is subsidization by the local, state, or Federal governments.

The nursing situation merely emphasizes the fact that serious economic issues lie ahead for all of the allied health professions.

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". . . Progress Is Still Too Slow"

Prepayment medical plans have not figured prominently in the news recently, not to the degree at least that they did a year ago. Medical journals also have had less to say on the subject. As a result, a number of physicians have inquired about the progress of these plans. Your Observer has personally received many such inquiries.

Reliable reports lead to the conclusion that while these plans have not shown spectacular growth, they are making satisfactory headway. But this is not good enough, according to Dr. L. H. Bauer, President of the Medical Society of the State of New York. Speaking to the Society at its annual meeting on May 5, he said:

"Our voluntary plans of insurance, which are but one factor in an improved national health program, have progressed more rapidly the past year, but progress is still too slow. Controversies between indemnity and service plans, and between non-profit and commercial plans must be eliminated.

"Whatever is best for the public must be our aim. The next few years will settle this matter once and for all and our action must be both progressive and agressive."

Dr. Bauer warned physicians against what he called the existing laissez-faire attitude on the part of too many doctors. He called upon them to assume militant leadership in guiding the public toward an improved and wider national health program. He also had something to say on Federal legislation. Favorable to the Taft-Smith-Ball-Donnell bill (see "New National Health Bill" in the May, 1947 issue of MEDICAL ANNALS), he said he endorsed this legislation in principle.

Readers of this column will be interested to know that the Senate Committee on Labor and Public Welfare has scheduled hearings on the TSBD bill beginning May 21. These hearings will long since have been held when this appears.

Returning to Dr. Bauer's views on a national health program, they might well be taken to heart by physicians, for they are those of every thinking medical leader.

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Perils in Psychiatry One cannot conceive of anyone reading ordinary reports for the pleasure that they give him. Usually they are dry as dust, and one reads them only to get at the facts. But there are exceptions to this rule, and the reports of Dr. C. Charles Burlingame, President and Psychiatrist-in-Chief of the Institute of Living at Hartford, Connecticut, to his Board of Directors are decidedly in this category. They are both stimulating and lively reading. In a field where personality peculiarities are not uncommon, he exhibits common sense and a refreshingly wholesome outlook.

In his most recent report to his Board of Directors (April 28, 1947), Dr. Burlingame warns of the danger of making people too conscious of their emotional well-being. He says:

"Throughout the country, hundreds of thousands of persons, satiated with a superficial knowledge of the psychological implications of life and literally preoccupied with psychiatric terminology, are beginning to interpret every trivial thought and feeling in psychological terms. Consequently, people in all walks of life are being instilled with the belief that they need psychiatric attention to save their minds, if not their souls.

"The result is inevitable. Although a medical evaluation of possible tuberculosis or cancer symptoms is available with reasonable promptitude to anyone, the vast majority of those seeking psychiatric advice will never have the opportunity to get within speaking distance of a psychiatrist, even to receive the assurance that no profound disorder is budding within their personalities, which is undoubtedly all that most of them need.

"There are approximately only 4,000 psychiatrists in the country, and unless this dangerous preoccupation with negative psychiatric matters is quelled, thousands of people seeking psychiatric assistance will be unable to have their conditions medically evaluated, and many who are delicately balanced will resort to the questionable succor of charlatans.

"We must admit that the early cancer technic has immense advantages, but it would be a cloistered psychiatrist who has not observed, as a by-product of its great good, its all too common evil of cancer neuroses and anxieties. Similar circumstances in psychiatry will give birth to the danger that an anxiety to see a psychiatrist will be overlaid on the initial anxiety, with no opportunity to obtain medical advice and assistance.

"I am not indicting psychiatry for this situation, but the problem is imminent; and whether it was created by psychiatrists, or by circumstances, or like Topsy, it just grew, the time is ripe for us to muster our forces against the rising tide of apprehension and misunderstanding."

Dr. Burlingame calls attention to the confusion which exists in the public mind because of "the rampant Bohemian differences of opinion concerning various psychologic and psychiatric procedures and technics which are being identified, or misidentified, with mental illness and the field of psychiatry." Responsibility for this situation, he says, is due largely to the intolerance of psychiatrists for the "other fellow's school of thought." This, he observes, is based more upon emotional reactions than objective analysis. He pleads with his fellow practitioners to forget their differences and subject themselves "to uncomprising self-scrutinization."

* * *

Indispensable Equipment

Last October when Dr. William W. Beckman of Harvard Medical School addressed the Annual Meeting of the Association of American Medical Colleges, he said: "My aim is that of all medical teachers—to equip doctors with all they need for the practice of medicine. An indispensable part of this equipment is ability to deal with social and environmental factors. All clinical teachers—wittingly or unwittingly—teach these factors; because they are inextricably woven together with the physical and emotional factors in illness."

In elaborating on this theme, Dr. Beckman lists the five basic skills which should be taught the medical student: "the skill in making full use of the relationship between student and his patient, the skill in interviewing, the skill in teamwork, the skill in the use of consultants, and skill in recording."

> "The first skill," he says, "is, perhaps, the most important. The patient has come for help. His need, in combination with his belief that the doctor can give him help, generates a very great force that becomes an important instrument in the management of his illness. Students must be taught how to develop this force and how to use it. . . ."
>
> "The patient cannot get help, nor can the doctor give it, without an interview. The interview is absolutely essential to the practice of medicine. I sometimes tell my students that I would rather look after a horse than a patient who does not speak English. At least, the horse's owner would give you some idea of what might be the matter. But even when patients speak your own language it requires skill to make an interview valuable."
>
> "Interviewing requires a knowledge of human nature and knowledge of self. The interviewer must be able to understand the motives behind the patient's actions. He must be aware of the part he plays in guiding the interview. Although questioning is important, it is not as important as listening and should be kept at a minimum. The patient must be allowed to tell his story in his own way, the interviewer keeping himself on the alert for such things as obvious gaps in information, topics that seem painful, inappropriate laughter, weeping, flushing, and so on. They will help him in his subsequent questioning. He will, in his own mind, be continually arriving at hypotheses of the true nature of the patient's problem. . . ."
>
> "The interview usually takes place as a private, personal affair between doctor and patient. It is rare, however, to find a situation where the doctor can handle the patient's care by himself. He usually enlists the aid of others—the patient's wife or landlady or some highly specialized scientist. In all such cases, the doctor and his helpers make a team, and skill in teamwork is one of the important things to develop in students. They must learn to work smoothly with others and to blend their own contribution with the goal of the team. Most important of all, they must be made aware of how absolutely necessary it is for members of the team to tell the patient the same thing. Nothing is more shattering to the patient's sense of security than hearing divergent points of view from the different members of the team. To achieve this necessary uniformity, the members of the team must confer with each other frequently."
>
> "Akin to teamwork, and necessary for its smooth operation, is the proper use of specialists, in other words, the bringing into the team of persons who can make a unique contribution to the patient's well being. This group includes other doctors, nurses, dietitians, physical therapists and, particularly, from the point of view of this paper, social workers. No one can be expert in all the skills of medicine, ranging as they do from such abstract fields of knowledge as the theories of nuclear physics to such practical ones as bed-making. And no one need be. The doctor must first know what sort of help he can get from the many specialists. Next, he must refrain from hampering them by suggesting procedures and technics. . . .
>
> "The last skill mentioned—skill in recording—is so obvious that you may wonder why I even bother to mention it. Recording is writing down what one has observed. In clinical practice one has to decide what is important and to indicate what one believes to be the relationship between the facts recorded. It is this subjective element which makes medical recording a skill. Students must be taught to see what is pertinent to the patient's problem and to record it clearly. They must realize that medical records are sometimes subject to public scrutiny and that no irrelevancy which might embarrass the patient should be included. In other words, skill in recording depends on skill in evaluating the information obtained."

In conclusion Dr. Beckman says:

> "A knowledge of mores and customs is essential to the doctor's understanding of his patients. He must know to what extent their behavior and their health are governed by their religious beliefs, their political convictions, their social status and customs. Doctors and students both must know what to expect of patients, families and society. . . .
>
> "Another thing that could well be taught by formal lectures are certain aspects of the role of social and environmental factors in disease. Here, I would include instruction in industrial disease, public health and sanitation, and nutrition. Also important is the influence of social and environmental factors in illness. The effect of environment in the cause of illness is not obscure when one thinks of the typhoid bacillus in the water supply or of the presence of silica particles in the air of a factory. Poor sanitation, poor nutrition and poor housing all breed disease. Many believe that poor emotional adjustment has the same result. All interfere with the proper management of disease. . . .
>
> "It is of first importance, also, to teach students about the many resources that are available for helping the sick, and how to use them. In most teaching institutions, medical social service links the hospital with other agencies such as public welfare, social security and others. Under such circumstances, all the physician needs to know is how to use medical social service, in the same way he uses other specialists."

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Free Discussions

Writers of editorials for medical journals are usually hesistant about taking issue with those with whom they disagree. It is much more pleasant to be agreeable, thereby avoiding controversy and criticism. This is at least one reason why most editorials are not worth reading. For subscribers seldom bother to read views with which they are already familiar.

Obviously, an editorial writer, if he is so inclined, can state views contrary to those of many of his readers and not be disagreeable. But let us say he does exercise care, setting forth facts and expressing honest opinions in a dispassionate, dignified manner, and that he still draws fire. Under such circumstances he should feel highly complimented. At least, what he had to say was not ignored. Usually, however, he is embarrassed by controversy and withdraws into his shell. At the very least, he is inclined to become more cautious. The net result, of course, is that he again contributes colorless material for his journal's editorial pages.

Apparently the editor of the *New York State Medical Journal* has had some experiences along this line. In the April 15 issue of the *Journal* he has this to say on this subject:

> "We are continually being cautioned about our editorials because they might hurt somebody's feelings. Why shouldn't they? . . ."
>
> "We think that if there is any place surviving for free discussion it should be in the editorial columns of a medical journal. Its audience is comparatively small. It is restricted, supposedly, to readers of education and intelligence. If any columns should be open to free expression of opinions, to the pursuit of truth, regardless of whose toes are stepped on, those of a medical journal should be the ones."

Your Observer agrees fully with these views. He believes that the majority of the readers of medical journals do too.

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Is This Your Home?

Physicians are frequently sentimental when they talk about country life. Some day, they say they will settle in some quite spot far removed from the turmoil of the world in which they live. The flaw in this picture is that the real thing is more often than not disappointing. A few days of quiet are usually more than enough for the vigorous doctor. He soon longs for what an editorial writer in the *Bulletin of the Medical Society of the County of Kings* (Brooklyn, New York) calls "a dreadful merry-go-round," in other words, the busy and sometimes feverish routine life in a doctor's home. The pattern of existence in a typical physician's household is described by the writer as follows:

> "Up in the morning . . . he gulps what he calls breakfast . . . off to the office . . . then to the hospital for rounds, operations . . . consultations . . . writing lectures . . . . classes, more office hours . . . then home for what used to be known in the family circle as dinner. Now dinner is swallowed in a few more gulps with the evening

newspaper propped before our medico's eyes. No conversation allowed—for who can eat, read and talk all at once? Mrs. M. D. may venture some little item of news, but such nonsense is ignored.

"The young people run to answer the telephone and to make dates for the evening. Mother feebly asks about homework—poor old soul! I wonder if she knows that we are living in the twentieth century. Homework went out with the kerosene lamp.

"The evening meal is passed by with the trite remark that 'the food in this house is lousy' and 'what makes things around here so off the beam?' or some other modern English remark which is 'Greek' to all the members of the family over twenty-one.

"Mrs. M. D. turns to projects either in or out of the home. These may run from a 'Home for Turtles' to 'The Life Cycle of the Rubber Plant.'

"She may become 'Madam President' and spend most of her life with a gavel in her hand, where motions to reconsider and the former motions are all skillfully bandied about without any regard for the memory of General Roberts. Bless her heart—she is alone so much that she must have something besides meals and dishes to keep her from going mad.

"Father comes home and Mother hopes he will have a few minutes to talk over some very important matter of welfare of the family, but not at present—the phone rings and one of his colleagues is on the other end to talk for an hour about the past meeting, the new system at the hospital, and the speaker for the next meeting while Mother stands with her new Easter bonnet proudly perched over one eye waiting for the approval of the head of the house. Does she get it? Father's eyes rove from the telephone and suddenly light on Mother's hat, but they do not see it until Mother asks, 'How do you like my new hat?' 'Is that thing on your head a hat!' The thing called a hat is flung back into the box and Mother has a queer choking feeling in her throat.

"Father goes to bed, turns on the reading lamp, and with a medical journal in his hand reads a line or two and falls asleep.

"Mother gently takes the journal from his hand, turns off the lights and is about ready to think of going to bed when—whrrr—goes the phone and the young man of the house begins a lengthy plea. After much discussion Junior finally breaks Mother down, and she consents to the gang coming back for toast, eggs, and coke. Poor Mother's head goes around like a top for she knows this means a session of the latest 'blue' music on the radio with singing 'in the groove' to match the noise coming from the radio.

"The one happy thought in her mind is that Father won't wake—he is too tired. He just snores and peacefully sleeps on.

"Finally, the last good-night is shouted across the street, the front door is slammed and Mother shudders and is thankful that the plate glass is in one piece.

"The children stamp upstairs like horses in a stall. Then all is quiet and Mother falls into a sleep of exhaustion.

"In what seems a few minutes Mother is awake—dressed and ready to jump on the merry-go-round for another day in the doctor's home.

"Would she change it? No! a thousand times no! for isn't she the doctor's wife?"

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Footnotes

The POSTGRADUATE LECTURES ON DIAGNOSIS II presented by the Society's Committee on Postgraduate Education in April were most successful. There were 335 physicians, residents, interns and medical students enrolled, a majority of whom attended regularly. Most of the credit for the success of this lecture course goes to Dr. Zigmond M. Lebensohn, Acting Chairman. His enthusiasm, plus the loyal support of the Committee, deserves high commendation.

* * * An article by Rita Halle Kleeman in *This Week*, entitled "Dr. Morgan's Strange Vacation," holds considerable interest for Washington physicians. The central figure in the story related by Miss Kleeman is Dr. William A. Morgan, a Society member, whose work among the people of the Dominican Republic has attracted wide attention. As an expression of their appreciation, the citizens of the Republic have erected a large modern hospital which they have named for him.

* * * The Third American Congress on Obstetrics and Gynecology will be held in the St. Louis Municipal Auditorium, September 8 to 12. Dr. Jed W. Pearson, 1834 K Street, N.W., local representative of the Congress, is anxious to interest Washington physicians in the program to be offered by the Congress and will welcome calls from those who contemplate attending.

* * * According to the District Health Department's Bureau of Vital Statistics, Washington

was an exceptionally healthy place in 1946. The general death rate reached a new low of 9.3 per 1,000 population. The report showed a general downward trend in the death rate since 1930, when it was 15.2 per thousand population. At that time the death rate for the Nation was 11.3.

* * * Dr. Louis N. Katz, Director of Cardio-Vascular Research at Michael Reese Hospital, Chicago, put on a demonstration at a recent luncheon of the Chicago Heart Association which made his audience sit up and take notice. Eighty-five of the Windy City's top-flight executives got what the United Press describes as "a glimpse of what success can do to the human heart." Dr. Katz had four hearts on display in large bottles. One was a normal heart, another was of abnormal size and belonged to a "hot-tempered newspaper executive who had a stroke," another was that of a department store executive "who wouldn't slow down when the doctor told him to," and finally, there was the heart of a man who had followed the physician's orders. He had a heart attack when he was sixty-five, and his physician had prescribed relaxation. He followed directions and died at eighty in his sleep. Now, Dr. Katz, it can't be as simple as all that!

* * * Pity the poor doctor! Dr. William T. Salter of the Department of Pharmacology of Yale University says: "It used to be said that the ordinary citizen resented having a new drug tried on him. In this modern age, however, the average citizen is in an experimental mood. Medical discoveries are announced in our daily press even before they are reasonably certain. The local physician is besieged on Monday morning by patients who have read a large metropolitan newspaper on Sunday about some new drug that most doctors have never heard of."

* * * The *Statistical Bulletin* of the Metropolitan Life Insurance Company, in a recent study of the ages of United States Senators, unearths in its usual thorough manner some interesting facts. "All told," the *Bulletin* states, "about one quarter of the Senators—25 out of 96—are under 50 years of age; 47, or about one-half of the total, are between ages 50 and 64; and 24, or the remaining quarter, are 65 years or older." The average age of the Senators is 56.3 years.

* * * This column will be missing from the July and August numbers of MEDICAL ANNALS. Your Observer is taking a vacation from most of his editorial duties until September.

T. W.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, May 26, 1947, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

Active Members

Theodore R. Coleman, 1835 Eye Street, N.W.
John James Kuhn, 2700 Connecticut Avenue, N.W.
James W. Long, 4822 Chevy Chase Drive, Chevy Chase, Md.
Joseph J. McCarthy, Jr., 3001 Que Street, N.W.
Royal Reynolds, 1830 Eye Street, N.W.
Norman Taub, St. Elizabeths Hospital
Jean J. Vivino, 18th Street and Bunker Hill Road, N.E.
Ferdinand Welebir, 1835 Eye Street, N.W.

Associate Member

Albert E. Long, 804 Prince Street, Alexandria, Va.

The following applicants for membership will be voted on at the meeting of the Executive Board, July 28, 1947:

For Active Membership

Joseph Michael Barker, Georgetown University—1939
William P. Chalfant, Jr., Hahnemann Medical College—1934
John D. Foley, Georgetown University—1929
Arnold S. Greenberg, George Washington University—1942
William L. Jamison, University of Virginia—1943
Marvin Hayne Kendrick, Harvard Medical School—1935
George Macatee, Jr., George Washington University—1939
George Porter Robb, Indiana University—1926
Francis J. Weber, University of Pennsylvania—1936

For Associate Membership

Charles R. Brooke, University of Maryland—1916
Fred R. Franzoni, Jr., George Washington University—1936
Ben Calloway Jones, Jr., University of Virginia—1938
Paul A. McNally, S.J., Fordham University—1921
Fred L. Soper, University of Chicago—1918

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OVERSPECIALIZATION

Carl B. Drake, M.D.

Editor, Minnesota Medicine

Editor's Note: Dr. Drake is the able editor of one of the most widely read medical journals in the Midwest, *Minnesota Medicine*. In view of his long experience as editor and his intimate knowledge of all things medical, the views he expresses here on specialization in nursing and medicine are decidedly worth careful reading.

In recent years there has been a decided tendency toward overspecialization in the medical field.

In the nursing profession educational requirements for certification of registered nurses have been increased to the point that a high school diploma and three years of training in a nursing school is the minimum, and two years of college work and three years in a training school is the requirement in certain schools. As a result a patient is required to have what amounts to a specialist if he is to enjoy the services of a trained nurse.

There has been a conviction for some time that such a long period of training is not essential to produce an efficient bedside nurse. While the longer period of training is desirable for turning out trained nurses who can qualify as supervisors in hospitals, instructors in nursing training schools, anesthetists and the like, any young woman with average intelligence should be able to learn enough of the practical side of nursing in a year's time to make her valuable as a bedside nurse to care for all but the seriously sick at home or in the hospital.

The present-day opportunities for young women to obtain well paid jobs without the necessity of spending several years in training have resulted in a lower enrollment in nursing schools. In 1946 only 31,000 enrolled in the nursing schools of the country compared with 39,000 in 1938. The lack of nursing personnel has forced the hospitals to abandon some 33,000 beds. The situation has become so serious that at least twenty-one states have passed legislation providing for certification of practical nurses who take a year's training in bedside nursing. This should enable the many hospitals which have been forced to close their nursing training schools because they were unable financially to meet the high requirements established by the national nursing organizations for the training of registered nurses, to open training schools for the training of practical nurses leading to a certification of certain attainments.

With the medical profession the tendency toward overspecialization is more marked. There are some 180,000 physicians in the United States, about 125,000 being members of the American Medical Association. In 1939 some 4,000 had been certified as specialists by the various boards. By March 1, 1946 the number had been increased to 26,108, an increase of over 3,000 a year since 1939. This figure of 26,108 does not include the thousands of specialists who have not taken steps to be certified by the various boards. A survey indicated that some 12,000 physicians in the armed forces planned to seek certification, which requires three to five years of hospital residency or the equivalent. At the beginning of the War there were 5,256 approved residencies, which had been increased by last year to 8,930, not including those in the Army and Navy hospitals nor those in the Vererans' hospitals. It would seem that there are just about enough residencies to care for the 12,000 who signified their intention to become certified. It should be stated, however, that an appreciable percentage of residents today are taking refresher courses, not intending to be certified. Nevertheless, a substantial crop of specialists is in the offing.

It is generally admitted that 85 per cent of medical ills can be cared for efficiently by the general practitioner. It is perfectly evident that we are about to have in the near future a much greater percentage of specialists than is required. As a result the specialists will gravitate to the centers of population, cut-throat competition will develop to the detriment of high grade medical practice. Large numbers will be forced to take up country practice for which they are not prepared and will have been subjected to great unnecessary expense in their training for the specialties. The answer is that the training of specialists should be curtailed and that promptly.

This overspecialization in the nursing and medical fields raises the cost of illness unnecessarily at a time when every effort should be made to reduce it so that medical care may be made more available to those in the lower income brackets. The training of practical nurses and general practitioners by means of courses specially adapted to needs is of the utmost importance.

D. C. MEDICAL BOWLING LEAGUE

Eighty-four doctors and their guests attended the Sixth Annual Banquet of the D. C. Medical Bowling League, which was held April 9, 1947, at Brook Farm, in Chevy Chase, Md.

Principal guests were Dr. John M. Orem, Superintendent of Sibley Hospital, one of whose teams took first place, and Mr. Theodore Wiprud, Secretary of the District Medical Society. Dr. Orem and Mr. Wiprud distributed 60 bowling trophies and numerous other prizes donated by friendly business establishments.

GOSH, I'M GLAD IT'S THE DOC INSTEAD OF ME!

Sixth Annual Dinner
D.C. Medical Duckpin League

Fourteen teams competed during the past season at the Brookland Bowling Alleys. Winning aggregations were as follows: first place, Sibley No. 2, Captain Dr. George H. McLain; second place, Prince Georges, Captain Dr. Charles Hageage; third place, Mt. Alto, Captain Dr. Alfred Dibbs; fourth place, Suburbanites, Captain Dr. Millard F. Ottman; fifth place, Garfield No. 2, Captain Dr. Frank S. Bacon.

Among the contestants who won high individual awards were Dr. George L. Ball, high doctors' League average, 114; Dr. G. Roland Gable, high individual set, 374; Dr. Sollie Katzman, high individual game, 160; Dr. Ottman, high strikes, 56. High team averages were won by Drs. Ball, Ottman, Willis B. Morse, George Resta, William R. Perkins, Jr., John Price, William G. Cushard, Robert L. Simpson, Roy G. Klepser, Joseph M. Cocimano, and Alfred Wilson.

In the season just concluded 88 bowlers participated, making one of the most successful years in the history of the League. Interest was high throughout the matches and competition was keen. The standings of the first five teams were not decided definitely until the last night.

One of the outstanding factors in the success of the past League year was the return of many

(*Continued on page 353*)

PROCEEDINGS OF THE ANNUAL BUSINESS MEETING

President William P. Herbst, Jr., presided at the Annual Business Meeting of the Medical Society of the District of Columbia held on May 7. About 175 members and guests attended the meeting and buffet supper which followed.

The annual "Reports of Officers and Boards and a Review of Committee Activities for 1946–1947," copies of which had been mailed to the membership prior to the meeting, and the Current Report of the Executive Board were unanimously adopted.

Following the business meeting, Dr. Oscar B. Hunter, Chairman of the Committee on Special Events, presided during a panel discussion on the nursing situation. Those who led the discussion were Dr. James A. Crabtree, Deputy Surgeon General of the U. S. Public Health Service; Dr. James A. Gannon; and Miss Elizabeth Earle, member of the Nurses' Examining Board for the District of Columbia.

Annual Report of the Chairman of the Executive Board

After reviewing briefly the activities of the Society, the Chairman called attention to the fact that the local Society is no longer a small organization. "In fact," he said, "it is much larger than many of the state medical societies, and so it must take on the responsibilities of a major organization. Situated in the Nation's Capital, it can have a tremendous influence on medicine in this country. It is your Chairman's hope that the Society will maintain its progressive record of the last few years, and meet with courage and foresight the social issues which will confront it."

The Chairman presented to the Society for final election applicants who had been elected to probationary membership by the Executive Board a year or more prior to the May meeting. This inaugurated a procedure which was provided for by Amendment XI to the Society's Constitution and By-laws with respect to election of new members.

Report of the Secretary

In presenting his report the Secretary pointed out that the year 1946 had been a reconversion period and that this Society, like most organizations, had not yet returned to a peacetime basis. He stated there were many reasons for this state of affairs but that, undoubtedly, the primary factor had been the influx of physicians. To quote from his report: "Not only have most physician-veterans who left the District of Columbia reëstablished their practices in the past year, but 329 physicians, a majority of them veterans, have come to Washington and are now members of the Society. . . . Correspondence and other 'paper work' have increased tremendously in the Society's office due to the rapid growth of the membership, and still the end is not in sight."

The Secretary pointed up his remarks on membership by presenting the following figures covering a five-year period:

	1943	*1944*	*1945*	*1946*	*1947*
Active	881	915	931	978	1,113
Life	64	63	70	76	82
Associate	212	204	214	215	233
Honorary	9	9	9	9	11
Total	1,166	1,191	1,224	1,278	1,455

The Secretary listed a total of 166 meetings which he had attended either in his official capacity or as spokesman for the Society. Many small meetings had not been recorded.

The 17th Annual Scientific Assembly, which had been cancelled in 1945 because of the wartime ban on nonessential travel, was held in the early fall. The year 1946 marked the transfer of the Assembly from the Mayflower to the Statler Hotel because showing of exhibits in the promenade of the Mayflower was prohibited by fire regulations. In spite of many adjustments necessitated by this change and unforeseen problems which arose, the Assembly was a great success, having a total attendance of 2,224.

Assistance was given the Committee on Postgraduate Education in presenting a series of Postgraduate Lectures on Diagnosis during April, 1946. As in the past, the Secretary coöperated with the Program Committee, which offered an unusually attractive series of meetings.

Due to the increasing demands made upon his time, the Secretary found it necessary to resign as a member of the Board of Directors of the Council of Social Agencies for the District of Columbia and Vicinity, but he continued to serve as a member of the Washington Metropolitan Health Council and its Executive Committee. He is also a member of the Public Health Committee of the Washington

Board of Trade. He withdrew as one of the Traffic Advisors to the District Commissioners but was prevailed upon to accept an appointment to the reorganized Traffic Advisory Board to the District Commissioners.

The new medical service plan, MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA, which represented months of effort by the Committee on Medical Care, in which the Secretary participated, was approved by the Society on June 19, 1946. He assisted with the organization of MEDICAL SERVICE and subsequently became the Secretary of the Board of Trustees of the SERVICE.

As Managing Editor of the MEDICAL ANNALS, the Secretary supervised the business affairs pertaining thereto and contributed regularly to the non-scientific portion of the journal. Dr. Wallace M. Yater, Editor of the ANNALS, had full charge of the scientific portion and selected and edited all material for publication. He was given valuable assistance by the staff of Associate Editors, who represent the various specialties in medicine. The Secretary reported an increase in the circulation of the ANNALS, from 1,750 in 1946 to 2,000 on May 1.

The MEDICAL BUREAU functioned smoothly and efficiently during the past year under the management of Mr. J. Richard Connelly, who is also Assistant Secretary of the Society.

During the year May 1, 1946 to May 1, 1947, the total number of subscribers had increased from 400 to 540. The BUREAU showed a net income over expenses for the year 1946 of $2,308.73, which funds will be used to finance the expansion of the BUREAU so it can function more efficiently.

As Group Treasurer for physician-member subscribers to Group Hospitalization, Inc., the Secretary reported an increase of 53 subscribers on March 1, 1947 compared to March 1, 1946, or a present total of 512 members of the group.

The Secretary accepted a number of speaking engagements in and out of Washington during the past year, and assisted with radio broadcasts. At the last Conference of State Secretaries and Editors held in Chicago under the auspices of the AMA, he was elected Chairman of the Committee on Arrangements for the next Conference, to be held in December, 1947 at the AMA Headquarters. He was also elected first Chairman of the Medical Society Executives' Conference, organized at Chicago in December, 1946, and will preside at the first annual meeting of the Conference to be held in Atlantic City on June 11.

In concluding his report the Secretary expressed his appreciation to employees of the Society for their loyal service and for the consideration and friendliness shown him and his staff by the Society's officers and members.

ELECTION OF OFFICERS

Since no nominations for office had been made at the March business meeting in addition to the slate presented by the Nominating Committee, a motion was made that a unanimous ballot be cast for the nominees selected. The following officers were elected:

President-elect: Dr. John Minor
First Vice President: Dr. Ivy A. Pelzman
Second Vice President: Dr. Carolyn H. Pincock
Member of Executive Board: Dr. William P. Herbst, Jr.
Member of Board of Censors: Dr. W. Ross Morris
Member of Board of Censors to succeed Dr. Harry F. Dowling, resigned: Dr. William W. Chase
Delegate to American Medical Association: Dr. Coursen B. Conklin
Alternate Delegate to AMA: Dr. Worth B. Daniels
Alternate Delegate to AMA to succeed Dr. Harry F. Dowling, resigned: Dr. J. Lawn Thompson, Jr.

Dr. Raymond T. Holden, Jr., the present President-elect, will assume office on July 1, 1947. Dr. Minor will become President on July 1, 1948.

REPORT OF THE BOARD OF CENSORS

The Chairman reported that because of the influx of physicians since V-J Day the Society's membership had reached 1,439, the highest in the organization's history. During the period May 1, 1946 to May 1, 1947 the Board had recommended 329 applicants for election as compared to 112 for the previous year. A survey will soon be made to determine whether the District and its environs have an adequate number of practicing physicians.

At its September meeting the Board recommended the election of Brigadier General Wallace H. Graham, M.C., A.U.S., to Honorary membership in the Society. His election occurred subsequently at a special business meeting of the Society, October 23, 1946.

CURRENT REPORT OF THE EXECUTIVE BOARD

As in past years there were matters taken up by the Executive Board at its April meeting which could not be included in the annual report of the Chairman mailed to the membership a week ago. Of necessity they are presented in this report together with unfinished business held over from the Special Business Meeting of the Society held on March 5.

With this report the Society has had presented to it all actions taken by the Board and its various committees and all matters of importance considered by them during the year. If an urgent situation involving policy should arise during the summer months, the Board will, of course, call a special meeting of the Society without delay.

Election of a Member of the Board of Trustees of Group Hospitalization, Inc.—In a communication received from Mr. E. J. Henryson, Director of Group Hospitalization, Inc., dated March 6, 1947, the Medical Society was requested to elect one trustee to the Board of Trustees of Group Hospitalization, Inc., to succeed one of the following members whose terms expire this year: Dr. Oscar B. Hunter, Mark Lansburgh, and George H. O'Connor (deceased). The Board at its meeting on March 24 voted unanimously to recommend Dr. Hunter's election to the Board for another term.

Proposed Amendment to the Constitution and By-laws: In its last report your Board presented the following amendment to the Constitution and By-laws creating a Section on Anesthesiology:

AMENDMENT XIII

> Section 1, Article II of Chapter IX of the Constitution and By-Laws is hereby amended by adding thereto the following:
>
> Section 6, on Anesthesiology.

It was stated that the above amendment would be voted upon at this meeting. Your Board heartily approves its adoption.

Election of Rear Admiral Clifford A. Swanson to Honorary Membership.—You will recall that Rear Admiral Swanson, recently appointed Surgeon General of the Navy and Chief of the Bureau of Medicine and Surgery, was proposed by your Board for Honorary membership at the March business meeting. As required by the Society's Constitution and By-laws, the proposal was referred to the Board of Censors which concurred in the Executive Board's recommendation.

As stated in its previous report, Admiral Swanson is widely recognized for his outstanding work in ophthalmology and otolaryngology. During the War he was engaged in research in color and night vision. He made studies of the effect of increased barometric pressure on the eye which were of tremendous value in deep-sea diving. He also made tabulations of oxygen consumption under varied barometric pressures which were valuable in the aviation field.

Our Society has conferred Honorary membership on the present Surgeon General of the Army and Surgeon General of the United States Public Health Service because of their outstanding contributions to medical science and the high office to which they have been appointed. Admiral Swanson's predecessor was also so honored.

Your Board is happy to recommend Admiral Swanson's election to Honorary membership in the Society.

18th Annual Scientific Assembly: Plans for the forthcoming ASSEMBLY are well under way. In fact, they are much more advanced than they were a year ago at this time for the 17th ANNUAL SCIENTIFIC ASSEMBLY.

As those who have served on committees responsible for the ASSEMBLY know, this meeting is a tremendous undertaking, requiring many months of planning and hard work. In fact, the ASSEMBLY is made possible only because of the sacrifice and effort on the part of the General Chairman and his committees.

The 18th ANNUAL SCIENTIFIC ASSEMBLY is scheduled for October 6, 7 and 8 at the Hotel Statler, Washington. From all indications, this will be the most ambitious meeting to date. A new feature, the Public Health Exhibit, will occupy the spacious Federal Room, and will be open each day throughout the three-day meeting to the public.

Your Board urges you to make plans well in advance to be present at all sessions of the ASSEMBLY.

Society's Participation in AMA's Centennial Broadcasts.—In commemoration of its one hundredth anniversary, the American Medical Association is sponsoring a series of Centennial broadcasts over the National Broadcasting System. Subject matter of these broadcasts is the lives of physicians in this country who have made outstanding contributions to medical science, or who have otherwise rendered distinguished service. Practitioners to be dramatized have been selected in consultation with medical societies in various parts of the country.

Our Society was called upon by the Association to suggest the name of some outstanding Washington physician, preferably deceased, whose work had nationwide significance. The Board canvassed the situation very carefully. Many names were suggested. Among them were Drs. Albert Freeman, Africanus King, William Holland Wilmer, A. Y. P. Garnett, Charles W. Richardson, and John Frederick May. From the group it was finally determined that Dr. May would be the ideal subject.

Dr. May was an eminent Washington physician during the Civil War. While he is best known to the general public for his identification of President Lincoln's assassin, John Wilkes Booth, he attained high eminence in his profession. He was the first Washington physician to perform an ovariotomy, and one of the first surgeons in America to perform a successful amputation at the hip joint. Those of you who are interested in knowing more about Dr. May will find a splendid biographical sketch of him by Dr. John B. Nichols in the August 1946 number of the MEDICAL ANNALS.

The broadcast in which Dr. May will be the principal character will be heard over the NBC network on May 31, the exact time to be announced within the next week or so.

District Bar Association's Study of Juvenile Delinquency.—Upon the request of Mr. Austin F. Canfield, President of the District Bar Association, your President appointed Drs. P. A. McLendon and Winfred Overholser as delegates to a meeting called by Mr. Canfield for the purpose of studying juvenile delinquency. These delegates have been instructed to participate as representatives of the Society in the establishment of a permanent organization which will devote its attention to this subject.

Your Board considers juvenile delinquency a very serious problem, and one to which the medical profession should give thoughtful attention. Your Board trusts that its response to Mr. Canfield's request meets with the Society's approval.

Amendments to Veterans Administration Contract.—Although few physicians have had occasion to render service under the contract entered into by the Society with the Veterans Administration, it is believed that eventually a number of our members will do so. At any rate, the contract will continue in effect until it is evident that there is no reason for its continuance.

The Veterans Administration recently submitted the following amendments and additions to the contract which your Board has approved:

AMENDMENTS TO CONTRACT VAm-22313 WITH THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

Par. 9 of contract VAm-22313 with The Medical Society of the District of Columbia, which provides that lists submitted by The Medical Society of the District of Columbia will be broken down by districts in order that the veteran for whom services are authorized may select a physician practicing in his home community, is hereby amended to provide that the choice of physicians, as referred to in the ninth paragraph, shall not apply to examinations for pension rating purposes.

Par. 15. This contract shall be effective from October 23, 1946 to June 30, 1947 and may be terminated by either party by giving thirty days' written notice to that effect.

Par. 16. This contract, if mutually satisfactory, may be renewed indefinitely for periods of one (1) year each, upon notice in writing to the contractor at least sixty (60) days prior to the expiration of each period of one (1) year, and written statement from the contractor within thirty (30) days after such notification agreeing to the renewal.

Creation of a Committee on National Emergency Medical Service.—All of the committees created to cope with the national emergency were discontinued by the Society following the end of the War. There seemed no necessity for their continuance. However, the Society has been requested by the American Medical Association to create a Committee on National Emergency Medical Service. Your Board believes the Society should comply with this request. At its last meeting, held on April 28, the Board voted that the Committee be created subject to approval by the Society.

AMA's Associated State Postgraduate Committee.—At each annual session of the American Medical Association, a meeting of the Associated State Postgraduate Committee is held. This Committee, made up of representatives of state medical societies (usually the President or the Chairman of the Committee on Postgraduate Education), assists medical societies in furthering postgraduate medical education. Discussed at its annual meetings are the methods by which this can be done. Your President has accepted an invitation to participate in the forthcoming meeting. Undoubtedly, he will return with many ideas as to how the Society's postgraduate program can be improved.

Conclusion: Mention has not been made in this report of the progress of the Society's medical prepayment plan, Medical Service of the District of Columbia. Several conferences have been held recently with representatives of Group Hospitalization, Inc., and an understanding arrived at with respect to nearly all matters. It has been necessary to develop a subscriber's certificate, a contract for participating physicians, and an application form for physicians who wish to participate in the plan. Finally, and most important, considerable discussion has been devoted to a contract between Medical Service and Group Hospitalization, Inc. Negotiations have now reached a point where it should be only a matter of weeks until all details have been agreed upon. When an agreement has been reached, it will be necessary for Group Hospitalization to make preparations for the operation of the plan, which will require about four months. The Service should be in operation sometime in the fall.

Finally, a word with regard to the past year. The Board is pleased with the progress which has been made, and believes that you will agree with its members that the annual reports reveal that a tremendous amount of effort has been put into the Society's program with eminently satisfactory results.

ANNUAL REPORT OF THE WOMAN'S AUXILIARY

The year 1946–47 was a very successful one, particularly from the standpoint of membership and attendance at meetings. Ninety-five new members were admitted during this year as compared to 15 for 1945–46. A regular meeting of the Auxiliary was held each month from October through May as well as a monthly Executive Board meeting. A tea in honor of the wives of service physicians, November 13, and the annual luncheon at the Congressional Country Club were outstanding social events.

Mrs. Tomas Cajigas, Chairman of the Program Committee, was responsible for the excellent programs offered during the year. Rear Adml. Forrest P. Sherman, Chief of Staff for Admiral Nimetz, was the first guest speaker. At the December meeting Miss Alice Hutchins Drake told the beautiful Christmas story which she does so charmingly. In January, Dr. W. W. Bauer of the AMA spoke on "Some Functions of the Medical Auxiliary." This meeting was unusually well attended, 76 members having responded to the President's plea for better attendance. "Current Attitudes Toward the Child" was the topic selected by Dr. Dorothy Donley-Dowd for February.

At the March meeting a poll was held to select the members of the Nominating Committee. Mrs. John J. Shugrue was elected Chairman; other members of the Committee, Mmes. Daniel L. Borden, Charles H. McEnerney, Edward L. Morrison and William L. Howell.

An unusual program had been arranged for the April meeting. Mrs. Herbert Gregor, the speaker, came armed with an array of flower containers and arms of beautiful spring flowers. She discussed the principles of flower arrangement, demonstrating with her own examples of the art. When she had finished, the room was filled with flowers arranged in a variety of ways.

Each regular meeting was followed by an appetising luncheon and social hour. Credit for the luncheons goes to the House Committee and to its very efficient Chairman, Mrs. George H. Crofton.

At the November meeting, upon the recommendation of the Executive Board, Mrs. William J. Mallory was voted an Honorary member of the Auxiliary. Mrs. Mallory, a former President of the Auxiliary, had submitted her resignation because of moving to Lovettsville, Va. with her husband, Dr. Mallory, when he retired from active practice in Washington.

The special educational project for the year was a partial scholarship, $100 per year, to enable a worthy young woman to enroll for the three-year nursing course at Georgetown University. During the D. C. Tuberculosis Association drive for funds, the Auxiliary manned a booth. Ten subscriptions to *Hygeia* were distributed to meeting places of young people. Three additional subscriptions were obtained from members and friends for distribution by the Auxiliary. Appropriations of $150 for the

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BLISS SUCCEEDS KIRK AS SURGEON GENERAL OF ARMY

On May 21 the Senate confirmed President Truman's nomination of Brigadier General Raymond W. Bliss to the office of Surgeon General of the Army, with rank of Major General, for a statutory term of four years.

General Bliss, who has served as Deputy Surgeon General since January 1, 1946, was sworn into office on June 1, succeeding Major General Norman T. Kirk.

Major General Raymond W. Bliss

General Bliss was born at Chelsea, Mass., May 17, 1888. He was graduated from Tufts College in 1910 with the degree of Doctor of Medicine, and was commissioned a first lieutenant in the Medical Reserve Corps in 1911. After two years of active duty he was commissioned a first lieutenant in the Medical Corps of the Regular Army. He graduated from the Army Medical College in Washington in June, 1913.

After tours of duty at various stations in the United States and Hawaii, he entered the Harvard Medical School in 1920 for a special course in surgery. In 1921 he became Executive Officer of the Hospital Subdivision of the Veterans' Bureau in Washington.

Subsequent to World War I, General Bliss served as Chief of Surgery at Sternberg General Hospital, Manila, P. I., at Fort Sam Houston and at William Beaumont General Hospital, El Paso, Texas.

He was a military observer in London from September 1940 to January 1941, and became Surgeon of the First Army and Eastern Defense Command in 1942. He was assigned as Chief of Operations in July 1943, and Assistant Surgeon General, August 1944, in the Office of The Surgeon General, Washington, D. C., serving in that capacity until his appointment as Deputy Surgeon General, January 1, 1946. He was made Assistant to the Surgeon General, February 1, 1946, with permanent grade of Brigadier General.

General Bliss, who was awarded the honorary degree of Doctor of Science by Tufts College in 1943, is a Fellow of the American College of Surgeons. During World War II he made extensive tours of the Pacific Areas, and later observed the Atom Bomb Test at Bikini. He has just returned to Washington from a two-month inspection trip through the European and Mediterranean areas.

The Distinguished Service Medal, Legion of Merit, French Legion of Honor, and the Award of the Italian Crown have been conferred upon him.

Under the guidance of General Kirk, who was appointed Surgeon General of the United States Army on June 1, 1943, the American Army in World War II achieved a record of recovery from wounds and freedom from disease never before accomplished in history.

For the first time surgery was taken to the man at the front; 96 out of every 100 wounded who lived to reach a hospital survived as against 92 in World War I. Mobile hospitals were set up within a few miles of the front lines and medical aid men went into battle with the troops, administering to the wounded where they fell. Prompt surgery, aided by penicillin, the sulfa drugs, whole blood and blood plasma administered at the front together with new and improved surgical technics, was responsible for returning 376,000 of World War II's 598,000 wounded to duty in the theater and an additional 55,200 to duty in the United States.

Through the Army's preventive medicine program deaths from disease were reduced to 0.6 man per thousand men per year as against 16.5 in World War I. Malaria was reduced from hundreds of cases

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Washington Physicians of Yesterday

RAYMOND THOMAS HOLDEN, SENIOR, M.D.

Dr. Raymond Thomas Holden, Senior, was born April 23, 1860, in Washington, D. C., the son of Thomas and Catherine Gleeson Holden. He attended Saint John's College, of Washington, and later the Medical School of Georgetown University, from which he was graduated with the degree of Doctor of Medicine in 1881.

He became a member of the Medical Association of the District of Columbia in 1883, and of the Medical Society in 1885. Participating actively in the affairs of the Society, he became its First Vice President in 1914, and was a member of various committees, including the Executive Committee 1916–18, and the Building Committee 1921–23. He was also an active member of the Clinico-Pathological Society, and for a number of years served on the staff of Providence Hospital.

He was a devoted member of Saint Dominic's Church, and later of the Church of the Sacred Heart; also a member of the Knights of Columbus.

On October 7, 1896, he married Celeste Selma Moritz. A son from this union is Dr. Raymond T. Holden, Junior, who also has had a distinguished medical career in Washington, about to be climaxed by his approaching assumption of the Presidency of the Medical Society of the District of Columbia.

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News and Personals

The Fifth International Congress of Pediatrics will convene at the Waldorf-Astoria Hotel in New York, July 14 to 17. An attendance of 2,700 pediatricians from 50 nations is expected. This will be the first meeting of the Congress in America, previous congresses having been held in Paris, Stockholm, London and Rome. Fourteen hundred delegates will attend from the United States and Canada, 450 from Latin America, 250 from Europe, and 100 from other parts of the world.

The Congress will be sponsored by the Section on Pediatrics of the AMA, the American Academy of Pediatrics, the American Pediatric Society and the Society for Pediatric Research.

From July 9 to 12 pediatricians from Latin America will meet with their colleagues in the United States at a **Pan American Congress** to be held in Washington, D. C., sponsored by the American Academy of Pediatrics.

A series of weekly **Lectures and Demonstrations in Cardiac Physiology and Electrocardiology** are being given at Prince Georges General Hospital on Thursday evenings at 8:30 p.m. under the direction of Dr. Leslie H. French. The series began May 29 and will continue for six weeks. The course is open to interested physicians and will be followed by a second group of lectures in cardiovascular diseases, with emphasis on modern therapeutic considerations. A nominal entrance fee is being charged to cover the cost of materials.

A fully equipped Heart Station has been established at the Hospital under the Department of Medicine, and this is being used as an adjunct to the course.

W. W. Norton and Company again offers the **Norton Medical Award** for book manuscripts written for the lay public by professional workers in the field of medicine. Terms of the Award have been slightly altered. The manuscripts may be submitted at any time, the Award not being limited to any one year. The Norton Award offers $5,000 as a guaranteed advance against royalties. Either complete manuscripts or detailed table of contents together with one hundred pages of manuscript may be submitted. Detailed information regarding terms of the Award may be secured from W. W. Norton and Company, Inc., 101 Fifth Avenue, New York 3, N. Y.

CALENDAR OF MEETINGS

May 5	Committee on Motion Pictures, Annual Scientific Assembly
May 7	Annual Business Meeting of Society
May 8	Washington Metropolitan Health Council
May 9	Committee on Public Health Exhibit, A.S.A.
May 10	Washington-Baltimore Psychoanalytic Society
May 12	Grievance Committee
May 13	District Dental Society
	Nominating Committee, Washington Metropolitan Health Council
May 14	Scientific Meeting of Society
May 21	Scientific Meeting of Society
May 22	Section on Anesthesia
May 23	Board of Censors
	Board of Trustees, Medical Service
May 26	Executive Board
	Pan American Medical Association, District Branch
May 28	District Diabetes Association

Those who desire to take the 1948 examinations of the **American Board of Obstetrics and Gynecology** may secure information and application blanks now from the Secretary, Dr. Paul Titus, 1015 Highland Bldg., Pittsburgh 6, Penna.

Members of the Society who avail themselves frequently of the **Army Medical Library** facilities will be interested in learning of a change in hours. The Library will be open on weekdays (except Wednesday) from 8:15 a.m. to 9:00 p.m., and on Sundays from 1:00 p.m. to 5:00 p.m.

Readers of the ANNALS are reminded to listen in on the **AMA radio program,** entitled "Stephen Graham, Family Doctor," which is heard over the Mutual network (WOL) each Monday night at 10:30 to 11:00 p.m.

The George Washington University Hospital is the recipient of a gift of $140,000 to complete its outpatient department and clinic from the Andrew W. Mellon Educational and Charitable Trust. In presenting this gift to the Hospital, the Mellon trustees said they had made an exception to the existing policy of the trust, which is to use the remaining assets of the fund to further educational and charitable projects in and around Pittsburgh, where Mr. Mellon lived for the greater part of his life.

In observance of **National Hospital Day,** May 12, the following hospitals held open house for visitors either on May 11 or 12: Arlington, Casualty, Children's, Columbia, Doctors, Emergency, Episcopal Eye, Ear and Throat, Freedmen's, Gallinger, Garfield, Glenn Dale, Mount Alto, Sibley and Suburban.

May 12 was the birthday anniversary of Florence Nightingale, whose work as an English nurse in the Crimean War first brought public recognition of the need for hospital and nursing care. Through the courtesy of **Dr. Frederick C. Fishback,** an original copy of Miss Nightingale's "Notes on Nursing" was on display at Suburban Hospital.

The Washington Committee for Education on Alcoholism held an **Institute on Alcoholism** at the Cosmos Club, May 8. Two sessions were held, afternoon and evening. Judge Walter J. Casey of the District Municipal Court presided during the afternoon when Community Action on Alcoholism was discussed. At the evening session, which was devoted to the Medical Aspects of Alcoholism, Dr. Winfred Overholser presided. Out-of-town speakers at this meeting were Dr. Howard W. Haggard, Director of the Laboratory of Applied Physiology, Yale University; Dr. Harry Tiebout, Medical Director of the Blythewood Sanatarium, Greenwich, Conn., and Dr. Martha Brunner-Orne, Consultant on Mental Hygiene, Wellesley College.

Preceding the AMA convention the **Army Medical Department** conducted a 3-day symposium at Walter Reed General Hospital on June 3, 4 and 5. The latest aspects of medicine and surgery, as applied and developed by the Army, were presented by outstanding leaders in their respective fields throughout the country. It is expected that the Army Medical Department will conduct a symposium of this nature annually, to be held each year at a different general hospital.

The following papers were presented by Washington physicians at this meeting: "Recent Advances in the Treatment of Lung Abscess," Dr. Brian B. Blades; "Intensive Psychotherapy," Dr. Norman Q. Brill; and "Testicular Tumors," Dr. Lloyd G. Lewis.

A new periodical, *Cancer Current Literature,* has been received in the Medical Society's office. It lists complete references to articles in the field of cancer which have appeared in the medical research journals during the previous month. About a third have been briefly annotated. It is prepared by the Medical Library of the American Cancer Society, 47 Beaver Street, New York 4, N. Y.

A series of radio programs, entitled **"About Children,"** began May 12 over Station WGAY. The programs, which are planned to give constructive health information to parents and others interested in child health, will be broadcast three days a week, Monday, Wednesday and Friday, from 10:30 to 10:45 a.m. Mrs. Richard A. Buddeka is in charge of the programs, which have the endorsement of the Medical Society's Committee on Radio Education. Each Friday a physician or dentist will be asked to make a personal radio appearance. Dr. Roy L. Sexton was the guest speaker, May 23.

After a number of preliminary meetings, dating back to May 15, 1946, the first formal meeting of the **Washington Society for the Advancement of Psychotherapy** (no connection with any other organization) took place on January 16, 1947.

Membership in the organization is at present limited mainly to two groups of physicians: (1) those who through years of active practice, experience and training have achieved an unquestioned competence in the field of psychotherapy, and (2) those who are in training. The latter may represent various degrees, from beginners to those who are close toward achieving final competence in psychotherapy.

The Third Annual Meeting of the Conference of Presidents and Other Officers of State Medical Associations was held at the Ritz-Carlton Hotel in Atlantic City, June 8. Speakers on the program were Senator Robert A. Taft, of Ohio, and Major General Paul R. Hawley, of the Veterans Administration. Senator Taft spoke on health legislation pending in Congress and General Hawley discussed recent experiences and future plans of the Veterans Administration Medical Department. Dr. L. Howard Schriver of Cincinnati, President-elect of the Conference, addressed the Conference on the medical profession's program to improve medical care.

The District of Columbia Society of Medical Technologists conducted an all-day seminar in the auditorium of the Medical Society's building, April 26. Dr. Oscar B. Hunter, adviser of the local Society, opened the meeting, after which the following scientific program was presented:

"Agglutination Tests for Rickettsial Diseases," Charles C. Shepherd, M.D., National Institute of Health
"Newer Methods in Serological Tests for Syphilis," Lt. R. Berlin, U. S. Naval Medical School
"Proper Handling of Stool Specimens in Amoebiasis," Eugene R. Whitmore, M.D., formerly Professor of Pathology and Parasitology of Georgetown University
"Recent Advancements in Laboratory Aspects of Antibiotics," Harold L. Hirsh, M.D., Clinical Instructor in Medicine, George Washington University School of Medicine
"Later Developments in Hematology," Joseph J. Wallace, M.D., Internist, Yater Clinic

In the evening Dr. Hunter was toastmaster at a banquet held in the Pan American Room of the Mayflower Hotel. The guest speaker was Colonel Elson B. Helwig, member of the staff of the Army Institute of Pathology.

The American Therapeutic Society held its 48th Annual Meeting at the Chalfonte Hotel, Atlantic City, N. J., June 6 and 7, just preceding the AMA Convention. Dr. Oscar B. Hunter, Secretary of the Society, presented his report at the business meeting. The following papers were read by Washington physicians during the scientific session: "Chronic Infectious Hepatitis," Dr. Oscar B. Hunter, Jr.: "Pulmonary Aneurysm—with Special Reference to Etiology and Differential Diagnosis," Dr. Arnold McNitt; "Allergy Review," Dr. Grafton Tyler Brown; and "Angiocardiography," Dr. George P. Robb. In a round table discussion on "The Management of Hypertension," Dr. Roger M. Choisser spoke on the pathological aspects.

At the **28th Annual Session of the American College of Physicians** in Chicago, April 28 to May 2, the following members of the District Medical Society were elected to Fellowship in the College: Drs. Louis K. Alpert, Herman S. Hoffman, Lawrence E. Putnam, Monroe J. Romansky and Rear Admiral Clifford A. Swanson, Surgeon General of the Navy.

Elected to Associate membership in the College were Drs. Lester S. Blumenthal, Thelma B. Dunn, Harold L. Hirsh, Bernard E. Nunez, Myer H. Stolar and John C. Sullivan.

The newly formed **Clinical Society of the Diabetes Association of the District of Columbia, Inc.**, presented its first program in the Medical Society's auditorium, May 28. Dr. Maurice Protas, Chairman of the Society, opened the meeting. Dr. John A. Reed, President of the District Diabetes Association, outlined the goals of that organization, and Dr. Joseph T. Roberts spoke on "Standardization of the Diabetic Clinics of the District of Columbia." The principal address, "Pitfalls in the Diagnosis and Management of Diabetic Patients before and during the Insulin Era," was given by Dr. William J. Mallory, Honorary President of the Association, who came from Lovettsville, Va., for the occasion.

The District Tuberculosis Association held its annual meeting, May 5. Among the speakers were Miss Jane Hoey, Association President, Dr. George C. Ruhland, District Health Officer, and Dr. Herman E. Hilleboe, Assistant Surgeon General of the U. S. Public Health Service. Dr. Hilleboe acted as moderator in a panel discussion on problems of rehabilitating tuberculous patients.

Mrs. C. D. Lowe was elected President of the Association, succeeding Miss Hoey, who has held the position for the past two years. Mrs. Lowe is Vice President of the Women's City Club and former head of the District Congress of the Parent-Teachers Association.

Dr. James J. Feffer was elected Vice President. Reëlected to office were Dr. Howard M. Payne, Secretary, and Alfred Lawson, Treasurer. Dr. Walter

K. Myers, Austin J. Latimer and Miss Hoey were named to serve with the officers as the Executive Committee.

Among those elected to the Association's Board of Directors were Drs. Clayton B. Ethridge, Thelma Hunt, Walter K. Myers and Theodore J. Abernethy.

The Clinico-Pathological Society met at the home of Dr. H. H. Kerr on May 20. Dr. Edward B. Broocks read a paper on "Erythroblastosis."

The Medical Society of St. Elizabeths Hospital held its tenth annual meeting and election of officers, May 2 and 3. Officers elected for the coming year were as follows:

Dr. Edgar D. Griffin, *President;* Dr. Zigmond M. Lebensohn, *Vice President;* Dr. Morris Kleinerman, *Secretary-Treasurer.*

The meeting concluded with a banquet at the Mayflower Hotel, at which the principal speaker was Dr. Vilhjalmur Stefansson, explorer.

Dr John Parks was invited to serve as associate examiner for the American Board of Obstetrics and Gynecology in Pittsburgh during the first week in June.

In August Dr. Parks will participate in a series of Postgraduate Clinics which are sponsored each year in various towns in Wisconsin by the Wisconsin State Medical Society. The towns selected for clinics this year are Stevens Point, Chippewa Falls and Superior, on August 7, 8 and 9. The clinics are conducted by specialists in four fields of medicine: surgery, internal medicine, obstetrics and gynecology (which Dr. Parks will represent), and orthopedic surgery with emphasis on poliomyelitis and other child-crippling diseases). Prepared papers are read by each physician on recent advances in his field, after which there is a general discussion and question period.

A new **College of American Pathologists** was organized at a meeting at the Drake Hotel in Chicago on December 13, 1946. Over 130 pathologists from almost every state and from Canada attended this meeting because of their personal interest in organizing the College. There were no official delegates from any society or other group of pathologists. The first regional scientific meeting was held in Indianapolis on April 7 at the Indiana Medical Center in conjunction with the State Pathology Society. Dr. Oscar B. Hunter, a member of the Board of Governors, attended a meeting of the Board in Chicago, May 18.

Dr. Frank Hartman of the Henry Ford Hospital, Detroit, retiring Secretary of the American Board of Pathology, was particularly active in the organization of the College and is serving as its first President.

Phi Delta Epsilon, a national medical fraternity, honored five Washington members by awarding them gold keys in recognition of 25 years each of distinguished service. The physicians so honored were Drs. Joseph Harris, Maurice Herzmark, David Davis, Gilbert Ottenberg, and Alec Horwitz. The presentations were made at a joint banquet of the George Washington University and Georgetown University Chapters at Woodmont Country Club, May 3. Dr. Davis was toastmaster.

Dr. C. Raymond Headlee writes that he was released from service in March and has begun a year's residency at Milwaukee Sanitarium, Wauwatosa, Wisconsin. Dr. Headlee expects to return to the District to enter into private practice in about a year. He maintained an office at 329 East Capitol Street before he entered the Army Medical Corps.

Dr. James R. Hurley is located permanently in Milwaukee, where he is practicing psychiatry. His address is 324 East Wisconsin Avenue. Dr. Hurley has been on active duty with the United States Public Health Service since 1942.

Dr. Oscar B. Hunter, Vice President of the Southern Medical Association, attended the Executive Committee meeting of that organization in Cincinnati in the early part of May. Dr. Hunter reports that the Association decided to accept the invitation of the Baltimore Medical Society to hold the annual meeting in Baltimore, November 24 to 27.

Dr. James N. Greear was invited to speak at the 28th Annual Meeting of the Virginia Society of Ophthalmology and Otolaryngology at the Cavalier Hotel, Virginia Beach, May 10. "A Review of Some of the Advances in Ophthalmic Surgery during World War II" was the subject of his address.

Dr. Charles Geschickter, Professor of Pathology at Georgetown University School of Medicine, participated in a symposium on "Problems of the Aging Patient," which was sponsored by the D. C. Physicians' Forum at the Willard Hotel, May 3.

Dr. Edward E. Richardson has been commissioned by the Progressive Citizens' Association of Congress Heights to write the history of Congress Heights for publication in pamphlet form. Dr. Richardson was President of the Association for 20 years.

Dr. Addison M. Duval, Assistant Superintendent of St. Elizabeths Hospital, discussed "Mental and Emotional Development of the Adolescent" at a meeting at St. Timothy's Church, May 1, sponsored by the Anne Beers Parent-Teachers Association.

Dr. R. Lomax Wells is now full-time Medical Director of the Chesapeake and Potomac Telephone Company, having discontinued his private practice.

Dr. George J. Stuart has been appointed Regional Secretary of the American Academy of Allergy, representing the states of Maryland, Virginia, West Virginia and the District of Columbia.

Drs. Walter A. Bloedern and Thomas M. Peery attended a Conference on Postgraduate Medical Education at the University of Michigan, May 19, 20 and 21, at the invitation of the W. K. Kellogg Foundation.

Dr. Leonard T. Peterson read a paper on "Spondylolisthesis" at the 46th Annual Meeting of the Association of Surgeons of the Southern Railway System in Charleston, S. C., May 15 and 16.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

Harvey Cushing, a Biography by John F. Fulton, M.D., Sterling Professor of Physiology, Yale University. Price, $5.00. Pp. 786, with 150 illustrations. Springfield, Ill.: Thomas, 1946.

Apahsia: A Guide to Retraining. Captain Louis Granich, U. S. Army Medical Administration Corps; appendix in collaboration with Sergeant George W. Pangle, U. S. Army Medical Corps. Price, $2.75. Pp. 108. New York: Grune & Stratton, 1947.

Acetanilid—A Critical Bibliographic Review. Martin Gross, M.D., Research Assistant (Assistant Professor) Laboratory of Applied Physiology, Yale University, with an introduction by Howard W. Haggard, M.D., Director, Laboratory of Applied Physiology, Yale University. Price, $3.00. Pp. 155, with 8 illustrations. New Haven, Conn.: Hillhouse Press, 1946.

The Ethicon Book of Sutures, compiled through consultation with leading operating room supervisors and surgeons and from extensive research in surgical and hospital literature by Miriam Zeller Gross, A.B., M.A. Price, $2.00; to students and members of the medical profession, 50 cents. Pp. 172 and xxviii, with 38 illustrations. New Brunswick, N. J.: Ethicon Suture Laboratories, Division of Johnson and Johnson, 1946.

Parergon, 3rd ed. Price, $5.00 Pp. 208, completely illustrated. Evansville, Ind.: Mead Johnson and Company, 1947.

A Handbook of Commonly Used Drugs. Michel Pijoan, B.A., M.D., Director, The Chemical Foundation Laboratory, University of Colorado, Boulder, Colorado; formerly Lieutenant Commander, M.C. (S), U.S.N.R., Naval Medical Research Institute, Bethesda, Maryland, and Clark Harvey Yeager, M.D., Dr.P.H., Chief of the Medical Section, Health and Sanitation Division, Office of Inter-American Affairs, Washington, D. C.; Lecturer on Tropical Diseases, Johns Hopkins Medical School and University of Maryland School of Medicine, Baltimore, Maryland. Price, $3.75. Pp. 198. Springfield, Ill.: Thomas, 1947.

Physicians's Handbook, 4th ed. John Warkentin, Ph.D., M.D., and Jack D. Lange, M.S., M.D. Price, $1.50. Pp. 282. Chicago: University Medical Publishers, 1946.

ARTHUR MORRIS ZINGHAN, M.D.

(1890–1947)

Dr. Arthur M. Zinghan, well known otolaryngologist, died April 30 at his home, 4448 Hawthorne Street, N.W. His office was located at 1801 Eye Street, N.W.

Dr. Zinghan was born in Baltimore, August 3, 1890. He received his early education at Mercersburg Academy, and his medical education at Georgetown University, graduating in 1912.

During World War I he joined a Red Cross group which went to Russia. He subsequently joined the Russian Army, serving in the Medical Corps with the rank of Lieutenant Colonel from 1914 to 1916. He also served one year with the British Expeditionary Forces, transferring to the United States Army Medical Corps in 1918, where he held the rank of Captain. He was awarded the St. Ann's Cross by the Russian Army and received a citation for "exceptionally meritorious and conspicuous service" from the U. S. Army.

After his discharge from service in 1919, Dr. Zinghan returned to Washington, where he joined the staff of Episcopal Eye, Ear and Throat Hospital.

He went abroad in 1928 and again in 1931 for postgraduate study in otolaryngology in Vienna. He was recently appointed Associate Professor of Otolaryngology at Georgetown University.

He was a diplomate of the American Board of Otolaryngology, a Fellow of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology, a member of the American Laryngological, Rhinological and Otological Society, Inc., the Southern Medical Association, and the International Medical Club. His Active membership in the Medical Society of the District of Columbia extended from 1916.

Surviving are his wife, Mrs. Katherine McQueen Zinghan, and a brother, Dr. Paul H. Zinghan of Ravenna, Ohio.

FRANK WHEELER HORNBROOK, Ph.B., M.D.

(1875–1947)

Dr. Frank W. Hornbrook, an Associate member of the Medical Society of the District of Columbia, died May 2 at his home, 4 West Melrose Street, Chevy Chase, Md. Dr. Hornbrook had been a resident of Washington and vicinity for the last 35 years, but had retired from active practice in 1927.

A native of Evansville, Indiana, Dr. Hornbrook was born October 25, 1875. He received his undergraduate training at DePauw University, Greencastle, Indiana, and studied for a year at the University of Michigan. He graduated in medicine in 1905 from Harvard Medical School, and first established a practice in Boston. For several months a year over a long period he took postgraduate courses at Johns Hopkins Hospital, Massachusetts General Hospital, and at hospitals in New York, Philadelphia, Chicago, and Rochester, Minn. In 1912 he moved to Washington.

He became an Active member of the District Medical Society in 1913 and transferred to Associate membership in 1923. He was a member of the Delta Kappa Epsilon Fraternity.

Two sons survive him, Frank W. Hornbrook, Jr., of Newark, Ohio, and Saunders R. Hornbrook, of Washington, together with a brother, John Hornbrook of Detroit, and two sisters, Mrs. Margaret St. John of Ennis, Texas, and Mrs. Lucy H. Bruning of Indianapolis, Indiana. His wife, Mrs. Anna Kelley Hornbrook, died in 1929.

ALEXANDER CHARLES RAGAN, M.D.

(1873–1947)

Dr. Charles A. Ragan, an Associate member of the Medical Society of the District of Columbia, died January 26, 1947, in St. Petersburg, Florida, where he had lived since last fall.

Dr. Ragan was born in Newport, Tenn., December 11, 1873. He graduated from Columbian University (now George Washington) Medical Department in 1900 and interned at Garfield Hospital. He was commissioned in the Regular U. S. Army in 1901 and held the rank of Lieutenant Colonel when he was retired for disability in 1917. He served as referee for the Travelers Insurance Company from 1920 to 1943.

Elected to Active membership in the District Medical Society in 1918, he transferred to Associate membership the following year. He was a Fellow of the American Medical Association and a member of the Association of Military Surgeons.

For a number of years he maintained an office in New York City at 55 John Street. His son, Dr. Charles A. Ragan, Jr., also resides in New York, and is a member of the faculty of Columbia University College of Physicians and Surgeons.

Research and Health—Parran

(*Continued from page 294*

The health sciences cultivated intensively and applied widely can raise to much higher levels our standards of human welfare. Science must be nurtured, not regimented. It flourishes best under democratic forms of government, in which the rights and freedom of the individual are cherished. Through this special genius of our people and the accident of contemporary history, the United States—if we seize our chance boldly—may lead the world in the demonstration of how the flowering of science enhances the well-being of mankind.

Yet the power of science to destroy equals or exceeds its power to promote our welfare. American leaders must remember that no civilization has endured in which physical and material progress was without a moral equivalent. Unless the moral and spiritual values of our lives also are nourished, cherished, developed in the Christian concept, all of science, even the healing, life-saving sector we are discussing tonight, will avail but little in the decadence of our own civilization. "For what does it profit a man to gain the whole world and lose his own soul?"

Science is neither a major nor a minor deity; not an end in itself. It is, rather, the most powerful instrument the mind of man has devised for quarrying into the unknown. I have pleaded these many years for opportunities in which the will and the skill of my colleagues might use it in the interest of good health for all the people. Under the moral leadership which you, the citizens of science, can offer, its use will implement our greater good.

Obstetrics and Gynecology—Parks

(*Continued from page 313*)

BIBLIOGRAPHY

1. Diamond, L. K.: New England J. Med., 1945, **232**, 447, 475.
2. King, E. L., and Davenport, J. W., Jr.: Am. J. Obst. & Gynec., 1946, **52**, 917.
3. Cole, J. T.: Ibid., 1947, **53**, 181.
4. Page, E. W., Hunt, M., and Lucia, S. P.: Ibid., 1946, **52**, 794.
5. Potter, E. L., Davidsohn, I., and Crunden, A. B.: Ibid. 1943, **45**, 254.
6. Burke, B. S., Harding, V. V., and Stuart, H. C.: J. Pediat., 1943, **23**, 506.
7. Eastman, N. J.: Am. J. Obst. & Gynec., 1944, **47**, 445.
8. Miller, H. C.: New England J. Med., 1945, **233**, 376.
9. Davey, J. F., and Daley, D. E.: Canad. M. A. J., 1945, **52**, 371.
10. Hogben, L.: Proc. Roy. Soc. Africa, 1930, **5**, 19.
11. Loughran, C. H.: Am. J. Obst. & Gynec., 1946, **52**, 42.
12. Cosgrove, S. A., and Chesley, L. C.: Ibid., 1946, **51**, 67.
13. Wilson, J. R.: Ibid., 1946, **52**, 273.
14. Everett, H. S., Scott, R. B., and Steptoe, P. P., Jr.: Ibid., 1945, **49**, 114.
15. Schumann, W. R.: Ibid., 1944, **47**, 93.
16. Mendelson, C. L.: Ibid., 1946, **52**, 191.
17. Lull, C. B., and Hingson, R. A.: New York State J. Med., 1944, **44**, 2331.
18. Siever, J. M.: Texas State J. Med., 1944, **40**, 316.
19. Lull, C. B.: Am. J. Obst. & Gynec., 1944, **47**, 312.
20. Parmley, R. T., and Adriani, J.: Ibid., 1946, **52**, 636.
21. Keettel, W. C., Diddle, A. W., and Plass, E. D.: Ibid., 1940, **40**, 225.
22. Cornell, E. L.: Ibid., 1941, **41**, 438.
23. Speert, H.: Ibid., 1943, **45**, 200.
24. Hutter, A. M., and Parks, J.: Ibid., 1945, **49**, 663.
25. Steele, K. B., and Javert, C. T.: Ibid., 1942, **44**, 783.
26. Moloy, H. C.: Ibid., 1944, **48**, 149.
27. Quigley, J. K.: Ibid., 1947, **53**, 271.
28. Moon, C. F.: Nebraska M. J., 1945, **30**, 197.
29. Waters, E. G.: Am. J. Obst. & Gynec., 1940, **39**, 423.
30. Norton, J. F.: Ibid., 1946, **51**, 519.
31. Daily, E. F.: Ibid., 1945, **49**, 128.
32. Hospital Care of Maternity Patients. Publication 314, United States Department of Labor, Children's Bureau, 1946.
33. Hospital Facilities Section, U. S. Public Health Service: Hospitals (no. 2), 1946, **20**, 52.
34. Moore, J. H.: Am. J. Obst. & Gynec., 1946, **52**, 993.
35. Eastman, N. J.: Ibid., 1945, **49**, 285.
36. Hamblen, E. C.: Ibid., 1946, **51**, 796.
37. Smith, G. V.: M. Clin. North America, 1943, **27**, 1373.
38. Crossen, R. J.: New Orleans M. & S. J., 1943, **96**, 93.
39. McLane, C. M.: Lancet, 1944, **64**, 346.
40. MacLeod, J., and Hotchkiss, R. S.: Am. J. Obst. & Gynec., 1943, **46**, 424.
41. Rubin, I. C.: J. Mt. Sinai Hosp., 1941, **7**, 479.
42. Montgomery, J. B., and Lang, W. R.: Am. J. Obst. & Gynec., 1946, **51**, 702.
43. Papanicolaou, G. N., and Traut, H. F.: Ibid., 1941, **42**, 193.
44. Ayre, J. E.: Ibid., 1946, **51**, 743.
45. Meigs, J. V.: Bull. New England M. Center, 1945, **7**, 49.
46. Gates, O., and Warren, S.: Am. J. Path., 1945, **21**, 567.
47. Miller, N. F., and Henderson, C. W.: Am. J. Obst. & Gynec., 1946, **52**, 894.
48. Scheffey, L. C., Thudium, W. J., Farrell, D. M., and Hahn, G. A.: Ibid., 1946, **52**, 529.
49. Scheffey, L. C., Thudium, W. J., and Farrell, D. M.: Ibid., 1943, **46**, 786.
50. Miller, N. F.: Ibid., 1943, **46**, 625.
51. TeLinde, R. W., and Galvin, G.: Ibid., 1944, **48**, 774.
52. Meigs, J. V.: Surg., Gynec. & Obst., 1944, **78**, 195.
53. Meigs, J. V.: Am. J. Obst. & Gynec., 1945, **49**, 542.

54. Meigs, J. V.: Progress in Gynecology. New York: Grune & Stratton, 1946.
55. Aldridge, A. H.: Am. J. Obst. & Gynec., 1942, **44,** 398.
56. Studdiford, W. E.: Ibid., 1945, **50,** 119.
57. TeLinde, R. W.: Operative Gynecology. Philadelphia: Lippincott, 1946.
58. Titus, P.: Am. J. Obst. & Gynec., 1947, **53,** 704.

Membership

(*Continued from page 336*)

Recent changes in membership status:

Active to Associate

George J. Brilmyer
John E. Hanby
Leslie K. MacClatchie
Anthony J. Nicolette
Raymond L. Schwartz

Resigned
Active

Wesley Fry

Resigned
Associate

Earl R. Templeton

Medical Bowling League

(*Continued from page 338*)

charter members and other physicians who had served in the armed forces.

Concluding the final match were two sweepstakes. The week following the last game, a sweepstakes held at the Brookland Alleys was won by Dr. William T. Saccardi. At the second, held at Bethesda following the banquet, Dr. John F. Finnegan was winner.

Increasing bowling interest among the doctors gives evidence that next year's competition will be greater than ever. Due to limited facilities, some doctors were unable to find an open place on a team, but in the coming year the League will endeavor to place all who so indicate before the start of the season, including the placement of more teams. Doctors or teams desiring to enter the 1947–48 season must make application to the officers prior to September 1.

Officers of the League are Dr. Resta, President, and Dr. Ottman, Vice President.

Annual Report of Woman's Auxiliary

(*Continued from page 343*)

Community Chest, $50 for the Washington Heart Association, and $10 for the District Tuberculosis Association were authorized. To raise funds for these and other projects the Ways and Means Committee, Mrs. Robert E. Moran, Chairman, sponsored a bridge luncheon and white elephant sale after the March meeting, and raffled a Dodge Sedan. The holder of the lucky car ticket, drawn from a bowl at the May meeting, was Dr. R. Lomax Wells. The Committee raised a total amount of $1,563.39 during the year, a most unusual showing.

The Auxiliary maintains an active interest in keeping the Library in the Medical Society's building attractive by adding improvements when needed. During the past year material for new glass curtains was purchased; the curtains were made by members. Consideration was given to installing fixtures and furnishing the room adjoining the Library as a powder room. A committee composed of Mmes. Maurice A. Selinger, A. Magruder MacDonald, Robert E. Moran and John J. Shugrue was appointed to carry out this endeavor.

New officers elected for the coming year are: Mrs. Moran, *President;* Mrs. E. J. Cummings, *First Vice President;* Mrs. William T. Davis, *Second Vice President;* Mrs. John E. Morris, *Corresponding Secretary;* Mrs. Richard E. Dunkley, *Recording Secretary;* Mrs. Crofton, *Treasurer.*

The delegate to the national meeting in Atlantic City in June will be Mrs. Oliver E. Thompson.

To the members of the Executive Board for their excellent suggestions and assistance, and to all members of the Auxiliary for their interest and faithful attendance at meetings, I wish to extend my sincere appreciation. I most earnestly urge each member to give the same splendid coöperation to my successor in office, Mrs. Robert E. Moran.

Mrs. William P. Herbst, Jr.
President

Bliss Succeeds Kirk

(*Continued from page 344*)

per 1,000 men per year to less than 50. The dysenteries, which once put entire regiments and armies out of action, occurred among less than 90 out of every 1,000 men per year and were readily controlled. During World War I, 38 per cent of the men who contracted meningitis died, compared with 4 per cent in this War; and 24 per cent of those who contracted pneumonia died, compared with only .6 per cent in this War. Through the development and use of toxoids and vaccines fear of tetanus, typhoid and typhus became a thing of the past. No deaths resulted from these diseases among troops inoculated against them. Not a single case of yellow fever occurred in the Army.

General Kirk retired from active duty, May 31, at the expiration of his four-year term as Surgeon General.

Washington Physicians of Yesterday—Holden

(*Continued from page 345*)

Dr. Holden engaged in the general and family practice of medicine, being at first located in Southwest Washington, and from 1915 in Columbia Heights. His practice was very large and extensive, and through it he attained high standing and esteem in the community and the profession. Despite his extremely heavy burden of work, he retained his strength and health with little impairment, and continued his practice and activities in full to the very last day of his life, a period of no less than fifty-six years. On October 16, 1937, he passed away in a sudden and unexpected cardiac collapse.

Qualities conspicuously displayed by Dr. Holden were the beauty of his character, his understanding sympathy, and the gentle charm of his manner and personality. The combination of professional ability with these personal characteristics made him ideally fitted for the practice of medicine. The ancient association of medicine with the priesthood had a profound significance, and the good physician even of today cannot attain his fullest usefulness and beneficence without still exercising the priestly element, the element that reaches the heart of humanity. Dr. Holden had that faculty, and in consequence was a fine example of the beloved family physician of tradition and story: rendering a lifetime of arduous and faithful service to his community; ministering to the ailing, comforting the sorrowing, and entering into the intimacies, the troubles, and many times the joys, of distressed hearts and homes; and earning the confidence, devotion, and love of a multitude of grateful patients, beneficiaries, and friends. To have lived such a life was a noble achievement; and Dr. Holden merits eulogy not only for his personality and character, but also as an embodiment of those fine ideals and traditions which the profession honors and cherishes.

These merits and virtues are not unique with Dr. Holden but pertain equally to the host of faithful and conscientious physicians who serve their families and communities so well. They are all likewise in position to experience and cherish the satisfaction and the thrill of rendering such noble public service.

JOHN B. NICHOLS, M.D.

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PREFRONTAL LOBOTOMY: INDICATIONS AND CONTRAINDICATIONS*

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PREFRONTAL lobotomy has been used as a method of treatment in certain mental disorders over a period of ten years. It seems fitting, therefore, that a survey of the field should be made with a view to greater precision in regard to indications and contraindications. It is natural for the psychiatrist who considers referring a patient to the neurosurgeon to inquire into the various possibilities for harm or for benefit; and it is natural for the surgeon to secure the coöperation of the psychiatrist both in the selection of proper patients and in the management and follow-up that are so important a part of any drastic therapy. The psychiatrist is interested in bringing to operation the patient who has not responded to other modes of therapy; the surgeon likes to keep his statistics as favorable as possible. It stands to reason that certain patients should not be considered for lobotomy because of the likelihood of recovery without operation, and it is also true that too much delay in undertaking lobotomy may witness such deterioration in the patient as to render the operation useless. In this paper we are attempting to show what type of patient may be expected to do well, and what type of patient should be excluded from consideration.

In order to accomplish this we are drawing upon our experience with some 450 patients operated upon between September 1936 and September 1946. All of the living patients have been seen or heard from during 1946. Many of them have passed through the convalescent period and attained better levels of adaptation than before they became sick; others have settled down to a humdrum existence, well below their youthful goal but nevertheless usefully occupied; some have retired, some have relapsed, some have remained in institutions, and some are dead. As a general survey of results tables 1 and 2 may be consulted showing the social adjustment and our estimate of the results obtained.

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*From the Department of Neurology and Neurological Surgery, George Washington University School of Medicine.

In presenting these tables we lay no claim to greater success than other investigators. Rather we ask ourselves in what way we could have secured better results. To some extent this can be answered by saying that we might have selected our cases more carefully with a view to excluding all those who could not be expected to recover. However, this is a rather unrealistic approach. We consider ourselves under obligation to push our investigations into untried or unpromising fields. So it is from our experience with the successes and failures of prefrontal lobotomy that we present some of our ideas in regard to the chances of success.

TABLE 1

Status of Living Patients, November 1946, 6 Months to 10 Years Following Prefrontal Lobotomy

DISEASE	NO.	REGULARLY EMPLOYED	EMPLOYED PART TIME	KEEPING HOUSE	AT HOME	IN HOSPITAL
	•	%	%	%	%	%
Schizophrenias	166	17*	11	8	37†	27
Involutional psychoses	104	6	4	40	37‡	13
Psychoneuroses	102	45	6	16	26§	7
Miscellaneous	6	17	—	—	33	50
Totals	378	21	8	19	34	18

* Includes 5 patients who were never employed before operation.

† Includes 7 patients who retired after working or keeping house for one year or more.

‡ Includes 9 patients who retired after working or keeping house for one year or more.

§ Includes 6 patients who retired after working or keeping house for one year or more.

Chances of Success

Age. Older patients as a rule are good candidates provided there is not too much dementia. A few seniles with manic reactions have responded poorly, however. Children are difficult to influence, requiring a maximum operation, and the same holds good with young adults whose schizophrenic or obsessive traits have begun before puberty.

Sex. Proportionately more women than men are able to leave institutions, probably because of the greater protection afforded them in the home.

Race. Eleven out of 13 negro females have been greatly benefited by operation, which is a higher proportion than for white females. Practically all of these were disturbed schizophrenics.

TABLE 2

Results oj Prefrontal Lobotomy (1936–1946)

DISEASE	NO.	RESULTS			DEATHS*	RECENT CASES†
		Good	Fair	Poor		
		%	%	%	%	
Schizophrenias	199	47	32	20	1	29
Involutional psychoses	128	62	20	15	3	11
Psychoneuroses	111	65	25	7	3	6
Miscellaneous	12	37	18	18	27	1
Totals	450	56	26	15	3	47

* Operative deaths only. Individuals dying subsequent to operation (22) have been listed according to results, good, fair or poor, during their postoperative term of life.

† Patients operated on since May 1946 have not been included in the percentage tabulation. Their number is stated in this column.

Education. College-trained people show better results than grade-school products. This probably reflects their emotional maturity at the period of life that they became sick. In the large group that completed high school there are many successes, but also some failures.

Occupation. In contrast to educational achievement, the simpler occupations witness a greater resumption of useful activity. There are some notable instances of return to teaching, law, business, and so on, but a greater proportion of success is found in clerical and mechanical occupations. No physician, dentist, artist, musician or writer has been able to make the grade, although from the relief of symptoms, most of these patients can be considered benefited.

Religion. Jewish people show a higher rate of success than others. This probably hinges upon the greater family solidarity manifested by these people.

Diagnostic category. Best results may be expected in chronic anxiety states and obsessive tension states with or without compulsions, although disagreeable behavior may be expected as a result of unleashed hostility and may require a long period to subside. Also, the continuation of the motor component of the neurosis may be a source of irritation to the family.

Excellent results may also be expected in hypochondriasis and in various psychosomatic disorders that prove rebellious and disabling. In a special category come a variety of intensely painful disorders in which the emotional component may well be secondary to the physical condition. We have recently reported on a series of such cases comprising tabes dorsalis, recurrent carcinoma, thalamic syndrome, etc., and are extending our observations to phantom limb and causalgia. While peptic ulcer, hypertension, asthma and arthritis have not been directly attacked, these conditions have tended to subside along with emotional distress in neurotic or psychotic individuals.

The involutional depressions offer a promising field for prefrontal lobotomy, taking up where convulsive shock therapy leaves off. Somatic conditions that might contraindicate shock therapy do not seem to militate against psychosurgery.

Decision in the manic-depressive psychoses is far from simple. As a rule of thumb, however, we are inclined to recommend operation only when the patient does not respond to shock therapy and when he is disabled more than half the time. Results in such few cases as have met our criteria have been gratifying.

Among the schizophrenics there are two bases for decision. Prefrontal lobotomy is indicated in young individuals early in the psychosis when it seems reasonably certain that other therapy will fail. Among these the periodic catatonics do the best, with paranoids next and hebephrenics and simple types last. As will be emphasized later, the emotional component of the psychosis is the outstanding phenomenon upon which to base the decision to operate. As long as the patient is still showing this tension a reasonably satisfactory result may be anticipated. Prefrontal lobotomy is also indicated in the chronically disturbed schizophrenic. We have operated upon patients who have been on disturbed wards for 10 years or more, and we have witnessed immediate subsidence of violent behavior with progressive reintegration of the personality and eventual discharge from the hospital. Of course, this does not always happen, but prefrontal lobotomy can change the whole character of a disturbed ward, and where it is applied on a substantial scale the back-ward problem of the mental hospital can be all but solved.

Our limited experience with other psychoses prevents us from speaking with confidence on the subject of epilepsy, criminality, psychopathic states, mental deficiency, drug addiction, organic brain disease and homosexuality. It is our opinion, subject to modification, that where such conditions have a groundwork of emotional tension, the results are apt to be gratifying, but the operation cannot be expected to alter the fundamental deviation of the individual. In other words, in such cases prefrontal lobotomy may be used to give peace of mind to a distressed individual, with the hope that the elimination of the distress will witness some improvement in the patient's adaptation to his surroundings.

Physical complications. Tuberculosis in a disturbed schizophrenic is a strong indication. Not only does prefrontal lobotomy do away with the disturbed behavior which is a menace to other patients and to the personnel, but it also enables the patient to rest and to enjoy his food, with resulting gain in weight and a tendency to healing of the tuberculous process. Two of our 7 patients with tuberculosis have subsequently succumbed to the disease.

Hypertension and heart disease in general are apt to be benefited. One patient with subacute bacterial endocarditis and frequent emboli has remained physically well for over 4 years after his cardiac condition was reactivated by insulin shock therapy.

Organic brain disease is not a positive contraindication if emotional distress is outstanding. Some of the psychotic symptoms seen as residuals of general paralysis may be relieved.

Advanced carcinoma, terminal hypertensive disease, acute infectious processes, and pregnancy, when they complicate a mental disorder, are contraindications to lobotomy.

Prepsychotic personality. We have seen a small number of cases in which the evaluation of the prepsychotic personality was insufficient. These were individuals who preserved the appearance of social adaptability but nevertheless manifested some cruel streak or avoidance of responsibility that after operation became greatly magnified. Such patients remained seriously aggressive and irresponsible for long periods after lobotomy had relieved their emotional tension. We assume that the clash of aggressive tendencies with socially restraining factors was an important source of the neurosis, and that the elimination of those controls allowed the patient to act quite naturally, but to the distress of the family.

Timid, docile, regressive individuals who seem to slip by degrees into an unchecked life of fantasy are also rather poor candidates for lobotomy because of the absence of emotional tension associated with their preoccupations. The giggly type of hebephrenic is among the poorest risks.

Excellent results, on the other hand, are observed in patients who from early life have been methodical, perfectionistic, and inclined to worry. Many such people go through life until they are overpowered by the adjustments necessary at the climacteric. Their preoccupations turn from the practical "What shall I do next?" to the unanswerable "What shall I do?" and they enter upon a round of unproductive and exhausting activity. The effect of lobotomy is to reduce the painful emotion that expresses itself in dissatisfaction with things as they are. As one husband said of his wife: "My God, Doctor, you should have operated on her 30 years ago!"

Domestic situation. We are strongly of the opinion that a satisfactory family situation is a great aid to recovery. Even an unsatisfactory family situation is better than none, and only a few patients have been driven back to the institution by the exasperating behavior of relatives. Patients who have been operated upon develop an amazing tolerance for overprotection. Also they can withstand parental rejection, sibling antagonism, conjugal disharmony, neighborly ridicule, discharge from employment and a host of other influences that would be considered quite devastating to a convalescing mental patient. The worst thing for these patients is to allow them to slip back into the rut of institutionalization. We are inclined to accept for operation badly deteriorated patients if the home situation is satisfactory. In cases in which families have closed ranks and in which there is nobody who will devote the time necessary to rebuilding the immature personality of the lobotomized patient, we are inclined to consider the patient for lobotomy only if he is a serious institutional problem.

Emotional status. We have left for the end the most important single criterion, the emotional status. In our observations we have continually been struck by the alteration in the affective life of the individual. Following prefrontal lobotomy there is relatively little disturbance in motor function, and this is only temporary. Likewise, as far as intelligence is concerned, there is little change following operation. It is true that the focus of attention shifts from the self to the environment and that introspection, contemplation and philosophizing are no longer feasible, but the loss of these qualities seems to point to a specific alteration in the locus of affect. In other words, it is not emotion that is lost. Operated people are emotionally responsive, sometimes emotionally incontinent or overresponsive, but it is to external situations rather than to internal ones.

The important point in selecting patients for operation is that they shall be emotionally responsive during the period immediately preceding the operation. Patients may be exceedingly disorganized, completely dominated by their hallucinations and delusions, confused, mute, resistive, disoriented, but as long as they are showing emotional tension there is hope of restoring them to the world of reality and then of rebuilding some sort of adequate existence. When the emotional life becomes extinguished and the patient no longer fights, then there is little hope of accomplishing anything.

We have come to depend upon criteria in 3 different categories for estimating the emotional charge: complaints, behavior, and autonomic status. The patient who has a series of complaints or the patient whose behavior indicates a situation close to desperation may be satisfactorily relieved. If neither is present, then the decision to operate depends upon the finding of disturbed visceral function, particularly on the sympathetic side. Large pupils, dry tongue, rapid heart, cold, moist and cyanotic hands betray at least a residual emotional tension upon which something may be built. Complete emotional dilapidation contraindicates prefrontal lobotomy. The more vivid the emotional response, other things being equal, the more conservative an operation can be carried out. When the emotional response is low and the psychosis is well structuralized over a prolonged period, satisfactory results may yet be obtained by severing additional fibers in the frontal lobes, but at some peril to life and more peril to adequacy of social behavior.

The outstanding contraindication to prefrontal lobotomy is emotional deterioration. The other contraindication is the possibility of spontaneous recovery. It stands to reason that such drastic treatment as prefrontal lobotomy should not be undertaken unless a patient is faced with disability or suicide and unless there is little prospect of recovery under other less drastic means. It requires sound clinical judgment to estimate the powers of recovery of the mentally sick individual. Some patients may remain sick for a number of years and still eventually make a complete recovery. Other patients after a stormy course seem to improve in their behavior and lose their complaints, but this may be a deceptive improvement, an improvement through deterioration. Such "burnt-out" psychoses are encountered not infrequently by various social agencies. Time relationships are not particularly important. Some schizophrenics are deteriorated beyond help when first seen by the psychiatrist. In the main, however, the prognosis in a schizophrenic psychosis should be fairly accurate before emotional deterioration is noticeable, and this deterioration would seem to require a year or two.

Response to shock therapy. Shock therapy is usually applied by psychiatrists before prefrontal lobotomy is considered, even in unfavorable cases; and sometimes the results are deplorable. Not only does a prolonged course of shock therapy delay the application of lobotomy, but in itself it lowers the emotional tension of the psychosis to a degree where behavior is fairly reasonable but not good enough for the patient to live outside an institution. In other words, emotional deterioration occurs because of, orin spite of, shock therapy (but only in some cases) and prefrontal lobotomy is robbed of its power to restore the patient to existence at home. As a rule, shock therapy is desirable in the affective psychoses even on repeated occasions or on a maintenance basis. In the obsessive tension states shock therapy has little virtue and in our opinion should not be pushed, although the patient and the family may be better satisfied to proceed with operation after a moderate number of shocks have shown the futility of continuing this method of treatment.

In the schizophrenic psychoses there is divided opinion as to the merits of shock therapy, which need not be discussed here. A favorable response to shock therapy followed by relapse is an indication that prefrontal lobotomy will be successful, but the reverse does not hold, particularly in long-standing cases. Our own lack of success in the shock therapy of schizophrenic states, even when accompanied by a rather strong affective component, has made us hesitate to inaugurate shock therapy. We would rather have the patient admitted to an institution for protection and treatment during the period of observation necessary to determine the recoverability of the attack. Then after a period of 6 months to a year, but not more than this, prefrontal lobotomy may be considered, if the patient is not getting well. Repeated schizophrenic episodes with more or less normality between times but accompanied by some "scarring" of the personality would seem to warrant operation at the onset of a relapse.

CONCLUSIONS

1. On the basis of 450 cases of prefrontal lobotomy followed for a period of several months to more than 10 years we have developed some ideas regarding indications and contraindications. The outstanding phenomenon upon which the prognosis is based is the severity of the emotional response to the abnormal ideas. When the affective component is strong there is a good chance of success; when it is weak there is a good chance of failure.

2. The attitude of the family toward the patient is a strong factor in his recovery to an adequate social existence.

3. Age, duration of psychosis, type of psychosis, and associated physical disease are of lesser importance.

4. Cruelty, avoidance of responsibility, and flight into alcohol before the development of the psychosis are contraindications.

5. Response to shock therapy is not a reliable guide, and this form of treatment can be used to the detriment of the patient.

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THE PSYCHOSOMATIC PHASE IN THE MANAGEMENT OF DIABETES MELLITUS IN ADOLESCENTS AND YOUNG ADULTS

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In the pre-insulin era the psychosomatic approach to the treatment of diabetes in the young formed practically no part of the treatment. Psychosomatic therapy had not yet in those times reached the widespread recognition it enjoys today. Furthermore, the hopelessness of the disease, which could only culminate in an early death, led to a fatalistic attitude on the part of the patient and his family. In most cases everything was done to ease the few short years left to the patient. He was put to bed, waited on, catered to, and slowly starved. Everyone sympathized with him. There was little else to do but wait for the end. No attempt was made to engender an attitude that he could lead a nearly normal life, because such was not the case. In those unenlightened days a diabetic was a hopeless invalid; little was done to prepare him for an adolescence or adulthood which he would never attain. Diabetes was a tragedy, a death sentence.

Twenty-five years ago came the discovery of insulin and with it hope for the diabetic. It also raised many problems in educating the patient and also his family in a radically new approach. Children who developed diabetes were no longer necessarily doomed but could have the same opportunity as non-diabetics to reach adolescence and adulthood.

However, attitudes developed over many generations cannot be eradicated overnight. The tremendous strides in the use of insulin to control diabetes were not matched with equal speed in the field of psychosomatic therapy. Consequently, even today we meet in our offices diabetics who developed the disease soon after the advent of insulin, who are subject to many misconceptions as to the restrictions under which they must exist. These patients offer a challenge to the physician to correct their misinformation and educate them.

This article aims to deal mainly with the psychomatic approach in adolescents and young adults, since unfortunately even today diabetics are frequently misinformed.

The psychosomatic approach to the treatment of diabetes must start at the same time as the treatment. In child diabetics this naturally means as soon as the disease is diagnosed. Not only will this encourage coöperation on the part of the child but also prevent the extension of mental conflicts into adolescence and adulthood. By doing this the actual control of the disease is enhanced. Of no less importance is the education of the adults associated with the child, for their attitude toward the patient is reflected in his mental response to his problem.

What is meant by the control of diabetes? We know that the control of diabetes does not merely mean a normal or near-normal fasting blood sugar and urinalysis negative for sugar and acetone, but a body that is well nourished by an ample, balanced diet, and emotional stability as well. Certainly an individual beset by groundless fears and a sense that he is unlike others is not likely to develop emotional stability. A properly informed patient (even children can be informed to the limit of their ability to understand) with a healthy mental attitude toward his condition will be a happier and more coöperative patient. Since the diabetic child now lives to adolescence and beyond, the problem that is created in him by psychologic mismanagement is increased and intensified by the time he reaches adolescence.

A maladjusted patient is very often afflicted with an erratic diabetes, not responsive to the ordinary rules of control. This, however, does not mean that all erratic diabetics are merely those who are emotionally upset. Infection, violation of diet, and omission of insulin are factors in the achievement of control. But in many cases, the last two factors are a manifestation of emotional disturbances, a revolt against the diabetic régime. The reasons for this revolt in young diabetics are usually unreasonable regimentation of the patient, too severe restriction of the diet, and too many "don'ts."

When an adolescent or young adult is forced to depart from the normal activities of his group, revolt is almost unavoidable, particularly since restriction of physical activity is unnecessary. Frequently the patient is made to feel very early that he is different from all others of his age, that he cannot and must not do this or that. His diet is, in a good many cases, restricted too much. He should be given the normal diet for his age (with the exception of candy, sweets, etc., which are really an accessory to normal diet). In addition he should be given insulin enough to control his diabetes.

Restriction of physical activity is cruel and unnecessary. A diabetic can do everything that a non-diabetic can do with the exception of eating certain foods and restricting the consumption of others. He should be so informed. To illustrate the importance of properly advising patients as to physical activities, the following 2 cases are herein cited:

J. G., a boy aged 15 years, was on 25 units of insulin. He frequently showed 4 plus sugar reactions in his morning urine specimens. One Christmas his mother bought him a bicycle, of which he was very fond—so fond, in fact, that he rode every evening for an hour. As a result, his insulin dosage was cut to 15 units daily, and his urinary sugar reactions became negative. His mother was instructed that as long as he continued his bicycle riding with regularity and followed his diet, the lowered dosage would probably be adequate. Naturally it was still necessary to analyze routine blood sugars on him. They showed plainly that control was maintained with the lower dosage, as long as he continued his bicycle riding.

Another child diabetic, who was particularly observant, called my attention to the fact that, over a period of years, his insulin dosage requirements always increased with the opening of school in the fall. Questioning revealed that during the summer he went to a playground daily, an activity which was curtailed during the school season. It was recommended that he attend a gymnasium class during his out-of-school hours. His subsequent lowered insulin requirements bore out our conclusions.

In pre-insulin days it was widely believed that lowered physical activity and concurrent lower basal caloric requirement somewhat alleviated the diabetes. Although this is no longer believed, a great many young diabetics have been told that their physical activity should be restricted. This is a definite fallacy, as exercise is good for diabetics and actually diminishes the insulin requirement, provided the exercise is not carried on to an exhaustive stage.

One of the most disturbing psychic traumas the young adolescent (particularly the female) frequently receives is the information, or rather misinformation, that she should never marry and have children. The importance of this psychic shock to a psychologically normal female cannot be overemphasized. It leaves her in a state of hopelessness. It gives her a mental response in which she feels as though life holds no future for her. This reaction has been noted very frequently in cases in which the diet has been violated and the diabetes left uncontrolled. When questioned about the reason for this attitude, a frequent answer the patients give is, "Well, what's the use? I can never have a normal married life and family."

The only premarital advice young diabetics should be given (in addition to the advice given any young patient) is that they should not marry a known diabetic or a mate who has a diabetic background if they contemplate having children. Prenatal diabetic care is of utmost importance in those cases in which the prospective mother is the diabetic. Pregnancy is not contraindicated because of the diabetes per se.

To illustrate the importance of the misconceptions concerning nondietary restrictions in young diabetics, the following cases are presented:

Case 1. H. D., a white female aged 27 years, married, had had diabetes since the age of 16 years. The disease was severe but was readily controlled on a diabetic diet and 65 units of insulin daily. She appeared in my office one day very much depressed and extremely nervous. Her husband, she related, was contemplating getting a divorce. At this time the patient had been married for 5 years. She was a graduate dietitian, and her husband was a graduate engineer. The reason for the proposed divorce was that, because of her diabetes, the patient had been instructed under no circumstances to become pregnant. Her husband would not agree to a childless marriage. The patient was advised to become pregnant, and that she would be given prenatal diabetic care. She did so. Her pregnancy resulted in a complete change in mental attitude and marital relationship. It was impossible to detect, in this happy woman, eagerly anticipating her child's arrival, any trace of the previous irritability and depression. About the middle of her pregnancy she developed a mild acidosis which promptly responded to treatment. At this time her husband was transferred out of the city, and she accompanied him. She continued her prenatal diabetic care in her new home. Her pregnancy was completed uneventfully and culminated in a normal delivery. Not only did her erroneous instruction almost break up her marriage, but it could have precipitated a subsequent psychic disturbance. Fortunately, she was properly instructed in time.

Case 2. M. W., a white female aged 21 years, single, was established as a diabetic at the age of 16 years. She was a college graduate. She was the child of an oversolicitous mother who treated her almost like an invalid because of her diabetes. She came to Washington to escape her home situation. Her knowledge of diabetes was negligible. After living in Washington for about 4 months she came to my office. She appeared to be highly nervous. When questioned as to her diet she claimed that she did the best she could. Her "best" did not include weighing or measuring her food, nor a familiarity with food values. She was on 45 units of protamine zinc insulin before breakfast. Besides her nervous condition she appeared to be considerably underweight for her height and build. When asked about her eating habits she stated that at times she would starve herself and at other times she would gorge herself, always with a sense of guilt. She complained of fatigue with a considerable lack of energy for her age. At that particular time her fasting blood sugar was 100 mg. per cent, and her 24-hour specimen of urine showed 7.3 grams of glucose. As far as her blood sugar and urine were concerned, this patient was under good control. However, her diet was not well balanced. She was 19 pounds underweight, and her normal blood sugar and satisfactory urine were obtained at the cost of a poor mental state, considerable lack of energy, and unbalanced diet. In addition, this patient had been told not to consider marriage. This information naturally added to her depressions. Her general attitude was one of despair. Upon diet correction and eradication of erroneous ideas, her weight was brought up to normal, her energy level raised, her mental attitude improved. Later she married, but unfortunately her husband adopted the same oversolicitous attitude the mother had shown. This returned her to a state of dependence from which she had been so laboriously extricated. Psychosomatic education in the direction of the husband was ineffective. The success of the psychosomatic approach was unfortunately short-lived because of the husband's attitude.

Case 3. T. L., a man aged 25 years, single, had been a known diabetic since the age of 19 years. His diabetes was discovered during the second semester of college. After having been under the care of a general practitioner for about a year, he was referred to me. The history given by the patient and substantiated by his mother was that up until the time of discovery of the diabetes the patient had been a highly social-minded individual. He was a typical boy of his age, engaged in athletics to a large extent, attended dances, and had the usual female companionship. With the onset of diabetes he began to change. He avoided his friends. He abandoned his social activities to a large degree and became introverted. His diabetes was fairly well controlled at times, but a great part of the time it was erratic.

When asked about the information that he had received about his diabetes—whether he was told about any restrictions, he said he had been given no information beyond dietary restrictions and insulin requirements. His mother frankly stated that she was worried about his change in general attitude. Apparently a good many of his ideas were the result of his own thinking. He confided that he felt definitely inferior. Although he occasionally mixed socially with members of the opposite sex, he shied away from any definite attachments, because he felt that he would be a burdensome husband. Even his associations with other men dwindled. This feeling of inferiority has increased, partly because of his being turned down by the Selective Service.

In spite of this mental handicap he did very well in school, and he now holds a responsible Government position. His only basis for his feelings of inferiority is his diabetes. Frequent attempts at psychotherapy apparently have failed to change his point of view. His diabetes at the present time is still erratic and this in itself may contribute to the feeling of inferiority and insecurity. In this case there is a vicious cycle.

The mishandling of this case from the beginning was the lack of positive assurance that the patient was normal in all other respects than his diabetes. This sensitive, intelligent young man developed definite ideas of his own following the shock of discovering that he was diabetic. These ideas are now so strong that it may be necessary to obtain psychiatric aid to adjust his emotional life. Had he been given positive assurance at the time of the discovery of his diabetes in all necessary respects, this may not have occurred.

Case 4. G. S., a white female aged 23 years, married, had been diabetic for a period of about 5 years. She had been poorly instructed in diabetic care. Her diet was random. She was taking 35 units of protamine zinc insulin daily. She had been married for 3 years. At the time she came for treatment she was in her third pregnancy and had bilateral cataracts. She was in a state of depression because of her visual difficulty, and the fact that she had gone to full term with 2 previous pregnancies only to bear dead infants. Intensely desirous of having a viable child, she was convinced that this pregnancy too would end in stillbirth. As a result of this conviction and her impaired vision, she was on the verge of mental collapse. She was given assurance that every effort would be made to see that this pregnancy would result in a viable child. In addition, she was told that the cataracts would be removed and an attempt made to restore her failing vision. Her diabetes was carefully controlled. In view of the history of her previous pregnancies, labor was induced about 4 weeks before term. The delivery was rather difficult due to the position of the child, but the child was born viable and normal. The change in the patient's mental attitude was dramatic. Her resignation to the belief that she could never have a child was replaced by elation. This was further increased by the successful removal of one of her cataracts. The following year the patient again became pregnant, and the same procedure was followed. The result was another viable baby. After this delivery the second cataract was removed. The third year the patient again was delivered of a viable baby.

According to the results which were obtained, it may be concluded that probably the prenatal diabetic care and certainly the obstetrical judgment were the causes of the first 2 stillbirths. The psychic effect of the viable births and the removal of the cataracts brought this patient to a normal attitude toward life and her ailment.

Case 5. D. S., a white female aged 25 years, single, had been a known diabetic since the age of 11 years. From that time on, her activities were radically restricted. Her exercise was limited. As a child she was made to feel "different" from other children her own age. As she grew older, she was instructed by her mother and her physician that she could not attend dances. She secretly violated this order, and while she enjoyed herself at the time, there invariably followed several days of deep depression. While attending college, she became very much interested in chemistry, but was told that in her "condition" 3 hours in a laboratory was too much for her. Because of the untenable conditions at home she took a position in another city.

At the time she came to my office she had not been to see a doctor about her diabetes for 4 years. Her diet was unregulated. She took her insulin haphazardly. Her fasting blood sugar was 360 mg. per cent, and her urine showed a 4 plus sugar and a 1 plus acetone reaction. She was on the verge of acidosis as a result of her complete revolt against her condition. She was depressed, nervous, and apprehensive about the results of her revolt. Her guilt complex, after 4 years of complete self-neglect, drove her to see a doctor. This patient was 69 inches tall and weighed 138 pounds; she was definitely underweight.

She was hospitalized for control. Along with the proper diet, insulin regulation, etc., she was given psychotherapy; an attempt was made to correct the erroneous view of her condition that had been impressed on her as a child and young adult. She was told that she could go to dances without a feeling of guilt; that there was nothing about her condition that contraindicated dancing. Because of this unusual exercise, she was instructed to decrease the dose of insulin before the dance. No longer did she experience depressions after each occasion. Her attitude became that of any young girl. Her weight was brought up to normal, and this improved her personal appearance. Her diabetes, which before had been very erratic, with the cessation of the internal mental conflicts became more amenable to control.

Case 6. R. M., a white male aged 25 years, single, was referred by a general practitioner about 6 months after the discovery of diabetes at the age of 17 years. The patient measured 5 feet 11 inches. His weight was 139 pounds and represented a loss of 25 pounds in the previous 6 months. He was in his third year of high school at the time. The advent of diabetes in this boy came rather as a blow. He was a fairly good student and was particularly interested in sports. The weight loss at the time of his coming to me was his chief concern, since as a result he was no longer able to participate in school athletics. He was greatly depressed. His blood sugar and urinary findings indicated that from those standpoints he was fairly well under control. However, he had achieved these results by rigid adherence to an inadequate diet. The patient was hospitalized for control, and his diet was adjusted to encourage weight gain. At the same time he was given positive assurance that ultimately he would be able to indulge in sports as he had done previously. With this as his goal, the patient actively coöperated. He was given all the other instructions and positive assurance that he could carry on the same as any non-diabetic individual, except in matters of diet and insulin régime. When his weight began to increase, his depression vanished. Over a period of about 3 years, his weight increased to 174 pounds.

In this case the strong desire for weight gain proved an excellent incentive. The patient continued his normal social relationships and the usual interests that a boy of his age enjoys. His receptiveness to positive education gave him such a solid ground for belief in his normal capacities that even his rejection by the Selective Service did not shake his confidence. His psychic adjustment was all that could be desired, and at the same time his diabetic control was maintained with relative ease.

SUMMARY

The prolonged life expectancy of diabetics due to the advent of insulin has given rise to many psychosomatic problems which were not apparent before. Now that diabetics have an increased life expectancy it is of great importance that they be properly educated in their mental approach. A fatalistic attitude that they cannot enjoy normal activities and a normal married life may lead them to non-coöperation, revolt and possibly psychic disturbances. Ideally, this educative process should start as soon as the diabetes is diagnosed. It is the physician's responsibility to encourage the development of a healthful mental attitude by informing the patient that practically the only restriction is dietary, and in cases in which it is necessary dietary supplemented by a regulated insulin régime. While diabetics who plan to have children should not marry other diabetics or mates with diabetic backgrounds, marriage to non-diabetics will lead to normal married lives and children.

It is important, where patients have been previously misinformed concerning their future outlook, that they be appraised of this misinformation for earliest correction. A diabetic who has been properly instructed and in whom a good psychologic balance has been established is more likely to be coöperative and amenable to control.

COMMON OCULAR AFFECTIONS OF CHILDHOOD*

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There are several general measures with regard to examination and medication of children's eye conditions which should be borne in mind. First, when attempting any examination of the child over 2 years of age (such as fundus examination or vision examination), as little restraint as possible gains a greater amount of coöperation and a lesser fear of what may be involved. (It must be recalled that most children entering the pediatrician's office, or any other office for that matter, immediately think of "needles" and other unpleasant procedures.) When dealing with the infant it is well to restrain him completely in order to get a view of the lids, cornea, conjunctiva or fundi.

Certain equipment would seem wise for every pediatrician when dealing with even elementary ocular examination and treatment. Small lid retractors and a pencil flashlight are essential for external examination. Pontocaine $\frac{1}{2}$ per cent for relief of discomfort; fluorescein 2 per cent for staining of corneal and conjunctival abrasions; sulfathiazole ointment 5 per cent ophthalmic and penicillin ointment and corresponding drops, and atropine sulphate solution $\frac{1}{2}$ per cent, all for medication; and an "E" chart and a Snellen letter chart for vision examination, would seem the necessary minimum. These may be supplemented by other forms of antiseptic ointment and drops.

Certain general measures of treatment should be recalled. Any ocular inflammation may be contagious, and semi-isolation in the form of separate towels, handkerchiefs, face cloths, and at times toys, would be wise.

When frank discharge is present, it is wiser not to bandage the eye, since the closed eye makes a nice culture site for infection. When there is a cut or abraded surface of the globe or lids, the eye should be bandaged.

It is not possible in the following outline to bring out all points of differential diagnosis or treatment, but the major ones are covered.

Affections of the Lids and Adnexa

1. *Blepharoptosis* (ptosis) may be congenital or acquired and should be referred to the ophthalmologist early. Surgery should be undertaken by school age, or sooner if vision or ocular motility seems to be affected.

2. *Hordeolum* (stye). The common stye is an infection of the root of an eye lash, usually is localized, showing a great swelling, redness and tenderness at or near the lid margin. It eventually comes to a "head," discharges thick pus and goes away completely. Treatment during the acute stage is not particularly helpful other than the use of hot compresses every 2 hours for about 10 minutes. These should be continued after the stye opens, for a day or two. I rarely incise a stye, since it is a painful procedure and nature soon accomplishes the same result. The use of 5 per cent sulfathiazole ointment or penicillin ointment 2 times a day for 2 to 4 weeks following the stye is wise in order to cut down the interval infection, and avoid recurrence or a series of styes. The eye should not be patched.

3. *Chalazion* (blind stye). The chalazion has an appearance similar to a stye except that it is less near the lid margin, less likely to come

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to a head and discharge pus, and usually leaves a more or less firm lump when the inflammation subsides. The chalazion is due to the blockage of a Meibomian gland with growth of granulation tissue within the gland. The best treatment is cold compresses during the acute stage, and incision and curettement through the conjunctiva after inflammation has subsided. At times chalazia occur as uninflamed lumps and must be treated the same as the previously inflamed ones.

4. *Blepharitis* (inflammation of the lid margin). Blepharitis is most frequently a chronic prolonged infection due to Staphylococcus aureus. The causes (and these are also true for styes and chalazia) are most commonly anemia, general debility, refractive errors, specific lack of resistance to the staphylococcus, and post-exanthematous infection. The treatment is relief of the causes, plus the use of sulfathiazole ointment at least once a day for several weeks.

5. *Dacryocystitis.* A chronic mucocele of the lacrymal sac or an acute infection may occur, particularly when the lacrymal duct is closed or narrow. Acute infections should be treated by hot applications, oral sulfa drugs, and oral or intramuscular penicillin. At times the sac must be incised through the skin. The chronic form is entirely in the hands of the ophthalmologist. Probing should be attempted, and if not successful, an operative fistula between the sac and the nose must be created (dacryocystorhinostomy).

6. *Lacrymal stenosis.* A most common occurrence in the newborn is an incomplete opening of some of the lacrymal drainage system. Usually tears are present in the eye from early in life, followed in a few weeks by purulent discharge. Some of the antiseptics mentioned should be used for the infection, and the tear duct probed before the age of a year for the stenosis. The older a youngster gets before the lacrymal apparatus is opened, the greater the percentage of failure will be.

Affections of the Conjunctiva

1. *Acute contagious conjunctivitis* (pink eye) is usually caused by the pneumococcus or Koch-Weeks bacillus, causing a very red, beefy eye with swelling of the lids and thick white or yellowish-white discharge. These cases should be isolated and 1 per cent zinc sulphate solution and 5 per cent sulfathiazole ointment used alternately every 2 hours following boric acid irrigations. Bandages should not be applied.

2. *Gonococcal conjunctivitis* in the newborn. This condition, called "ophthalmia neonatorum," manifests itself within the first 4 days of life by acute redness, intense swelling, and thick purulent discharge from the eyes. Smears will show the gonococcus. The cornea is not often involved in the newborn. Careful use of silver nitrate at the time of birth will prevent most of these cases (Crede prophylaxis). In the older child gonococcal conjunctivitis manifests itself similarly, but the cornea is less resistant to infection and corneal ulceration must be watched for. In both the newborn and the older child, the intramuscular use of penicillin and irrigation of the eyes every half hour followed by 5 per cent sulfathiazole ointment, for the first 24 hours, every 2 hours for 24 hours thereafter, and not less than 3 times a day for a week thereafter, would seem wise. Strict isolation should be carried out and the unaffected eye carefully protected with a cover glass.

3. *Inclusion conjunctivitis.* The condition most commonly confused with ophthalmia neonatorum is inclusion blenhorrhea, which clinically appears about the same but rarely shows up before the fourth day and usually by the eighth day after birth. Conjunctival scrapings stain with Giemsa stain and reveal intracellular inclusion bodies. The treatment of this condition is exactly the same as for the gonococcal condition. At times children will pick up an inclusion conjunctivitis from swimming pools. Usually the acute phase is

less acute and the chronic phase more prolonged than in the newborn. This condition also responds well to the sulfa drugs and penicillin.

4. *Vernal conjunctivitis.* This condition is truly allergic, manifesting itself as red, watery eyes with intense itching and some stringy mucoid discharge. The "limbal" variety shows a line of fine beads about the corneal margin, while the "lid" variety shows a multitude of papules and cobblestone elevations on the conjunctiva of the upper lid particularly. The treatment is frequent irrigations and cold compresses, protection from light and heat by dark glasses and a broad brimmed hat, and some slightly anesthetic antiseptic astringent drops. I use the following prescription often:

Cocaine hydrochloride..........	gr. $\frac{1}{4}$
Neosynephrin $\frac{1}{4}$%..............	dr. 1
Zinc sulphate..................	gr. $\frac{1}{2}$
Distilled water q.s. ad.........	oz. 1

This may be used as often as every 2 to 3 hours. If the vernal conjunctivitis is truly and intensely seasonal, investigation to find the allergen should be attempted.

5. *Virus conjunctivitis* (possibly related to inclusion conjunctivitis). During the past number of years I have seen many youngsters with moderately red, irritated eyes having watery discharge but no pus or mucus. On staining with fluorescein a multitude of pinpoint erosions of the cornea could be seen. No specific drug has been found helpful. The prolonged use of sulmefrin drops, metaphen (1 to 1000) or other antiseptics, eventually helps control the condition. Salves are unwise. No visual loss has been noted.

6. *Chronic conjunctivitis* and blepharitis have been mentioned as due to debility, refractive errors, exanthemata, etc.

7. *Silver irritation.* One of the commonest explanations of discharge in the eyes of the newborn has been that it was due to an irritation from silver nitrate. This is not often true. Most of the time the condition was due to unrecognized inclusion conjunctivitis. However, silver irritation does cause redness or some mucoid discharge during the first couple of days but should clear up within 3 days if no infection is present.

Affections of the Cornea

1. *Corneal abrasions* due to finger nail, twigs, edges of paper, etc., may be serious and should be treated at once, preferably by an opthalmologist. If the patient complains of a feeling of foreign body, the eye tears profusely, and has considerable photophobia, a corneal abrasion is probably present. Staining with fluorescein will reveal a bright green area easily seen on the cornea. This eye should have 1 drop of $\frac{1}{2}$ per cent atropine solution instilled, sulfathiazole ointment 5 per cent applied, and a firm bandage put in place. The eye should not be left open until the cornea no longer stains and the symptoms have disappeared. If infection occurs, a corneal ulcer is then present.

2. A *foreign body* loose in the conjunctival sac or on the conjunctiva causes few symptoms. However, a foreign body even though minute, if on the cornea or under the upper lid, will cause a scratching feeling, tearing, and photophobia, which may not be constant but recurs until the foreign body is removed. Both in corneal abrasion and in foreign body, a drop of $\frac{1}{2}$ per cent pontocaine solution instilled in the conjunctival sac will make examination much easier because pain is relieved. A foreign body under the lid may be removed with impunity. One on the cornea requires additional anesthetic and delicate maneuvering. When a foreign body is removed from the cornea the eye should be patched for at least 24 hours.

3. *Corneal ulcer*

a. *Catarrhal ulcers* usually occur about the limbus in conjunction with an acute conjunctivitis and respond to the same type of treatment.

b. *Dendritic ulcer* (thin branching lines of erosion) require a general anesthetic and thorough currettement of the ulcer and a pressure bandage (a job for the ophthalmologist).

c. A *serpent or infected ulcer* is extremely serious, causing an intensely red eye, a marked grey area of the cornea, and extreme, deep-seated pain. This should be referred to the oculist at once because the globe is in danger.

d. *Phlyctenular keratoconjunctivitis.* This is a condition associated with poor hygiene and poor nutrition and frequently with a positive intradermal tuberculin, in which a mucopurulent conjunctivitis with irregular corneal ulceration occurs. The patient has a very watery eye with swollen lids and a marked photophobia. Hospitalization with the use of ½ per cent atropine 3 times a day, hot applications, antiseptic ointment, high caloric diet, high vitamin intake, and ultraviolet therapy (to the skin and at times to the eyes) are helpful. This condition tends to recur and frequently leaves a badly scarred cornea with visual loss.

e. *Interstitial keratitis.* This condition, due to congenital lues, occurs usually between the ages of 3 and 15 years, manifesting itself by a greying central area of the cornea which becomes more widespread, a marked tearing, photophobia and pain. Local treatment is the same as with (d). In addition, treatment of the syphilis with heavy metals and with penicillin is indicated. Unfortunately, the unaffected eye may become affected even in the midst of treatment, and a considerable amount of corneal scarring reduces vision if the inflammation continues more than 2 or 3 weeks.

Miscellaneous Affections

The following conditions are not common but should be recognized by the pediatrician and will be commented on briefly.

1. *Orbital cellulitis.* This is an acute inflammation of the orbit most frequently due to transmission of ethmoid infection on the same side. The lids become acutely swollen, the globe pushed forward and limited in motion, and the child is usually acutely ill. The treatment is primarily treatment of the sinuses, intramuscular and oral penicillin and sulfa drugs, and finally, incision and drainage of the orbit, if and when the infection would seem localized (the oculist's job).

2. *Congenital cataract.* The pupil may be perfectly clear or completely white at birth. During the first number of weeks of life a previously clear pupil may become hazy and densely cataractous. In any event, early operation (within the first year or two) is indicated. The operation is usually a "needling," which consists of slitting the anterior capsule of the lens so that the aqueous can enter into the lens cortex and cause absorption. Two or more needlings may be necessary, and at times a linear extraction is wise.

3. *Congenital glaucoma.* At times within the first 6 months, because the out-flow machinery for the intraocular fluids is defective, the pressure within the eye becomes too great, the cornea assumes a blue-gray appearance, the anterior chamber becomes deeper, and the eye feels hard. Early operation is indicated, but the prognosis is not good in any event.

4. *Retinoblastoma.* This malignancy, frequently called retinal glioma, first manifests itself within the first several years of life by an appearance of a yellow reflex from the pupil in certain lights. Examination of the fundus shows a yellow-white lobulated mass or masses extending into the vitreous. The growth travels back through the optic nerve to the brain by direct extension. Immediate enucleation is indicated. About 25 per cent of the time the second eye is involved, and then the decision between a second enucleation and radiation therapy must be made. Recently, improved use of prolonged X-ray therapy has improved the possibility of cures in those second eyes.

Vision and Refractive Errors

These will be commented on only briefly. It is well to differentiate between poor vision, on the one hand, and ocular discomfort (asthenopia) on the other hand. A fact frequently ignored is that discomfort is not due to how well or how poorly one sees, but to how hard one has to work in trying to see well. Many children with a myopia see very poorly at distance and never have discomfort. Other children on their routine school tests (and in your office) manage to read the 20/20 line but still complain of headaches and tired eyes.

1. *Vision testing.* I do not use picture charts for children below the school age. Too much depends on previous experience. I do use the "E" chart as put out by the National Society for the Prevention of Blindness. It is rather simple to teach the child to hold his fingers in the direction that the fingers of the "E" go, and with a little practice, it is accurate. The only other point I would like to make is that, when I am assured that the child understands the testing method, I only have him indicate 1 letter on each line until he begins to fumble. Then I have him indicate every letter on that line. If you expect the child to indicate every letter from the top down, he becomes tired or disinterested by the time he reaches the 20/40 or 20/30 or 20/20 line (the ones we are particularly interested in). The above test is very satisfactory for children from the age of 4 through 7. From 7 years up, the ordinary Snellen letter charts are quite satisfactory. I also only indicate 1 or 2 letters on each line for those children until they begin to fumble. Vision should be tested in each eye separately, taking care that the eye being covered is thoroughly screened but is not being pressed upon.

2. *Asthenopia* (discomfort due to eye use). If a child has an excessive hyperopia (farsightedness) or a moderate or excessive astigmatism, the effort of accommodating to overcome this refractive error and still see well will cause headaches, tired eyes, red, irritated lids, unexplained nausea, or poor progress in school which cannot be otherwise accounted for. This may be true in spite of the fact that the child gets 20/20 vision on the testing chart. He should be examined under cycloplegic (preferably atropine) and if a refractive error of any considerable amount is found, glasses for school and close work should be prescribed.

3. *Poor vision.* In myopia, and at times in excessive hyperopia and astigmatism, the child is not able to accommodate and see well, and the only symptom may be inadequate vision. In this case again, refraction under cycloplegic is essential, and glasses should be prescribed for the times the eyes are being used. In the case of myopia, it should be recalled that it first appears between the ages of 8 and 14 years in children who previously had good vision. The cause is not known. There is a tendency for myopia to get somewhat worse up through the teens and to level off in the upper teens and lower twenties. Myopia does not improve at any age. Glasses give good vision but do not cure or prevent myopia. Exercises, the use of vitamins, diet, medication, and a thousand other suggested remedies affect myopia little, if at all.

4. *Glasses.* Spectacles or glasses should be understood properly. Except in the case of squint (strabismus), glasses do not influence the future of eyes whatsoever. Glasses simply allow the individual to see better, more comfortably, and perform the job better as of the time they are being worn. Wearing glasses now will not prevent the onset of myopia or prevent ocular difficulties in the future. Also, the wearing of glasses does not make eyes worse, and except in the case of those having an excessive refractive error, glasses do not cause a feeling of dependence. Glasses, then, influence the present favorably, but do not influence or control the future.

STRABISMUS

This condition will be discussed in a subsequent lecture. I would now simply point out to you that strabismus causes no discomfort, while "phoria" (latent tendency for eyes to go out of line) may cause discomfort similar to E-2. Also, true strabismus must, in the small child, be differentiated from an appearance of strabismus due to epicanthus, asymmetry of the face and lids, narrow pupillary distance, or a broad flat bridge to the nose.

Special Groups of Affections

1. *Birth inflammations.* It is well to distinguish between conditions which cause watering, discharge, redness, and swelling of the lids in the newborn.

a. *Ophthalmia neonatorum* occurs within the first 3 days and has a thick discharge, swelling of the lids and redness, and a positive smear for the gonococcus.

b. *Inclusion blenorrhea* occurs between the fourth and eighth days and presents a similar picture. Inclusion bodies are found on smear.

c. *Non-specific conjunctivitis* may occur from the first couple of days, usually is less acute, and the gonococcal and inclusion bodies are not found on smear.

d. *Silver irritation* occurs within the first couple of days and usually disappears within 3 or 4 days without any particular treatment.

e. *Lacrymal stenosis* causes watering from the first few days and some mucopurulent discharge after the first couple of weeks, but without any particular inflammation.

2. *Exanthema and the eyes.* Attention should be called to the care of the eyes during and following some of the acute contagious diseases of childhood. During measles, chicken pox, scarlet fever, etc. the eyes need to be protected from light only for comfort. The light does not damage eyes, and so the shades need not be drawn unless the child wishes it. Moderate use of the eyes is suggested, since during a weakened condition a squint may show up if the eyes are used excessively. Antiseptics in the form of sulfathiazole ointment, metaphen solution, etc., should be instilled twice a day to avoid the post-exanthematous difficulties. Following the exanthema, blepharitis, conjunctivitis, and styes are not infrequent. As suggested before, cleansing and the prolonged use of sulfathiazole and penicillin are indicated.

In conclusion, I would like to call your attention to the fact that certain inflammations of the conjunctiva and lids (acute contagious conjunctivitis, silver irritation, blepharitis, styes and chalazia) may well be taken care of by the pediatrician if he knows when to call for help. On the other hand, some other affections, particularly those involving the cornea, such as corneal abrasions, ulcers and the like, orbital cellulitis, and gross congenital anomalies had best be sent to the ophthalmologist promptly.

In final comment, I would like to emphasize the point that the mere finding of 20/20 vision does not preclude the possibility that refractive errors may be causing headaches, tired eyes, nausea, inflamed lids, and poor school progress. However, 20/20 vision associated with no eye symptoms would suggest that the eyes are in good condition.

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HEADACHE—MECHANISMS, DIFFERENTIAL DIAGNOSIS AND TREATMENT*

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VASCULAR HEADACHES

Migraine, although too often used loosely to designate any chronic or recurrent headache, is nevertheless an important and commonly occurring entity. The typical attack is heralded by the occurrence of visual phenomena such as scotomata or field defects. It is followed in 15 or 20 minutes by a throbbing hemicranial headache which lasts for hours to days and is often associated with nausea and vomiting. That there occur partial and abortive forms in which some of the features are absent or altered cannot be questioned, but the uncritical extension of the concept invalidates its usefulness. The painful hemicranial headache of migraine has been shown to be due to distention of cranial arteries, chiefly the branches of the external carotid artery and possibly the dural arteries, while the pre-headache visual phenomena are related to occlusive vasoconstriction of cerebral arteries (Schumacher and Wolff[2(a)] and Sutherland and Wolff[2(b)]). The frequent familial occurrence of migraine suggests the importance of the hereditary and possibly of the constitutional factor in the disorder. Certain similarities between migraine and epilepsy and the usually accepted dictum that the ancestries of migraine patients are heavily weighted with epileptics has led to the theory that there is a generic relationship between the two conditions. However, as impressive an authority as S. A. K. Wilson[21] disputes the validity of this, and electroencephalographic studies have been contradictory. That a small proportion of migraine sufferers have an allergic background or predisposition has long been known, and recently a relationship on an allergic basis between migraine and Ménière's syndrome has been postulated (Atkinson[22]). On the basis that the vascular mechanisms of migraine are precipitated by the release of histamine into the blood stream as the result of an allergic reaction, Thomas and Butler[23] have used histamine in the treatment of migraine in a manner which will be described.

Migraine tends to occur in individuals of a certain type of personality make-up which has been described by Trowbridge, Cushman, Gray and Moore[24] as being indecisive, insecure, perfectionistic, compulsive, sensitive, anxious, and easily discouraged. In many respects migraine is akin to the psychoneuroses, and the importance of emotional conflicts and problems in the genesis of attacks cannot be overestimated. In this sense it is well to regard the syndrome as occurring on the soil of a migrainous predisposition which may be activated by many kinds of factors of which the emotional is among the most important.

Any condition for which there are a great many therapies cannot be considered to be handled entirely successfully by any one of them, and this is certainly true of migraine. To abort individual attacks, agents which constrict the branches of the external carotid artery are most efficacious and of this group ergotamine tartrate (gynergen) is the most widely used. It is most effective when administered intravenously or intramuscularly (0.25–0.5 mg.) during the pre-headache stage. Oral and sublingual doses of 3 to 5 mg. taken during the same stage are often equally successful. If taken properly, ergotamine will abort or terminate 90 per cent of attacks.[25] A modification of this drug, dihydroergotamine, which is said to be equally effective and less toxic, has recently been introduced (Horton, Peters and Blumenthal[26] and Blumenthal[27]). Other vasoconstrictors which have been used with varying degrees of success are caffeine, 100 per cent oxygen by inhalation, and benzedrine sulfate taken orally or intravenously (Gottlieb[28]).

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Methods of therapy based on the allergic hypothesis mentioned above have been advocated by Atkinson[22] and by Butler and Thomas.[23] The former uses nicotinic acid starting with 6 to 8 intravenous injections of 20 to 30 mg. and increasing by daily increments of 5 to 50 mg. This is followed by daily intramuscular injections supplemented by 50 to 100 mg. orally. Butler and Thomas use intravenous histamine injections (2.75 mg. of histamine phosphate in 500 c.c. of isotonic saline injected over 4 to 8 hours), and report excellent results.

One of us (L. B.) is now giving intravenous histamine in a different manner. He uses the same dilution as Butler and Thomas but gives it for only 1–2 hours. This same amount is given 3 times a week for several weeks. Once improvement is attained, the patient is instructed to give himself histamine subcutaneously daily. By this method it is found that the percentage of good results is increased. The entire treatment is given as an ambulatory office procedure.

Other drugs used include potassium thiocyanate in daily doses sufficient to produce a blood concentration of 2.5 mg. to 8 mg. per cent (Engle and Evanson[29]) and the new antihistamine preparation, benadryl (Blumenthal and Rosenberg[30]).

To become so absorbed in trying the new drugs which come and go almost overnight as to forget that the migraine victim is a complicated human being is an attitude disastrous to successful therapy. It is essential that a psychotherapeutic approach be combined with whatever medicines are used, and time spent with migraine patients can not be occupied more profitably than in going over their life situations and their relation to the occurrence of headaches. The relief of symptoms has been reported by psychoanalytic therapy alone (Fromm-Reichmann[31]).

HYPERTENSIVE HEADACHE

The usual or typical headache of essential hypertension, like the migrainous headache, is vascular in origin and has also been found to be associated with dilatation and stretching of the extracranial and, to a lesser degree, the dural arteries. The similarity between the two conditions is emphasized by the fact that migraine has been found to be five times as common in hypertension as in a group of controls (Gardner, Mountain and Hines[32]), while a significant number of hypertensives have had migrainous headaches before the onset of their hypertension (Sutherland and Wolff[2(b)]). In this regard it is interesting to speculate on the possible influence of the rather similar types of personality make-up which are found in migraine and hypertension, with repressed and unconscious hostility being of psychodynamic importance in both.

Neither increased blood pressure (Sutherland and Wolff[2(b)]) nor increased spinal fluid pressure (Shelburne, Blain and O'Hare[33]) are directly correlated with the occurrence of headaches in hypertensives, and drugs reducing blood pressure are not very successful in relieving the headache.

The typical hypertensive headache is dull or throbbing, often predominantly frontal or frontotemporal, and is present on awakening, or awakens the patient in the early morning. Nausea and occasionally vomiting may be associated. It should be emphasized that neither these characteristics nor the mechanisms described apply to the severe cephalalgia associated with hypertensive encephalopathy. This is often unilateral, may radiate to the back of the neck and maybe associated with anorexia, vomiting, apathy or restlessness, amblyopia, convulsions, papilledema, and extreme elevation of the blood pressure. Local edema of the brain resulting in traction on, or displacement of, the tributary veins to the great venous sinuses appears to be the mechanism involved in the headache of hypertensive encephalopathy (Rosenberg[34]).

In the treatment of the typical hypertensive headache ergotamine tartrate and caffeine have been found to be useful, as might be expected from the similarity in mechanism to the headache of migraine. Steiner[35] has recently reported good results by the use of 10-inch blocks under the head of the patients' beds. Psychotherapeutic measures varying from advice as to living habits to exploratory technic are again an important element of a rounded treatment régime. Maintenance of a blood level of 8–12 mg. per cent of potassium thiocyanate often controls recurrent hypertensive headaches. Many patients can obtain relief of severe headaches after undergoing lumbar sympathectomy.

The importance of histamine as a weapon in the experimental elucidation of many types of headaches has been mentioned. The headache produced by the intravenous injection of this substance is the result of mechanical stimulation of pain-sensitive structures in or near the walls of intracranial arteries caused by distention of the relaxed walls by blood driven in under increasing pressure (Friedman, Brenner, and Merritt[2(f)]). It will be noted that this mechanism is similar to that operative in migraine and hypertensive headaches, except that in the case of histamine the intracranial rather than the extracranial arteries are principally involved.

HISTAMINIC CEPHALGIA

Not to be confused with the experimentally-produced histamine headache is a clinical entity, the so-called histaminic cephalgia described first by Horton, MacLean, and Craig.[36] This is a severe unilateral throbbing headache occurring usually in middle-aged individuals in attacks of an hour or less in duration, which characteristically occur at night and are associated with homolateral rhinorrhea, lachrymation, and sweating. They are made worse by recumbency and alcohol and are relieved in the erect position. Sometimes swelling of the temporal vessels may be noted during an attack. In contrast with migraine headache, there is usually no family history, no relation to menarche or menses and no associated scotomata, nausea or vomiting. In susceptible individuals, attacks can be easily precipitated by the subcutaneous or intravenous injection of 0.1–1.2 mg. of histamine. Horton[37] states that the pain follows the branches of the external carotid artery; this is rather interesting in view of the findings of the Cornell group that in experimental histamine headache the arteries principally involved are the intracranial ones. Although "histaminic cephalgia" undoubtedly occurs, it is probably more common in incomplete or partial forms than in the full-blown syndrome, which is rather infrequent. One of us (L. B.) has treated only 1 classical case in 15 months. During this same period of time, he has treated 70 typical cases of migraine. Since histamine is not an antigen, it is incorrect to speak of a sensitivity or an allergy to histamine. Certain individuals appear to have a lowered tolerance to histamine. Just how histamine in quantities large enough to cause symptoms is released into the circulation is conjectural. There may be something in the way of an antigen-antibody reaction in or upon the endothelial cells of vessel walls releasing histamine into the blood stream from within the cells (Spriggs[38]).

The decision as to whether histamine "desensitization" should be carried out in a given case is sometimes facilitated by observing the effects of 0.1–1.2 mg. histamine intravenously. If the specific headache complained of by the patient is reproduced it seems worth while to attempt this type of treatment regardless of the precise details of the headache. However, this cannot be considered an infallible test, and treatment has on occasion helped people with headaches not reproduced by the test dose. The "desensitization" may be carried out by the subcutaneous method of Horton, in which, after an initial dose of 0.25 c.c., doses increasing by 0.05 c.c. are given twice daily until 1 c.c. has been reached. The intravenous method as described under the treatment of migraine often brings about a remission in the headaches more rapidly than does the subcutaneous injections. Once relief is obtained, however, it is wise to follow this up with the above outlined subcutaneous injections. Graduated doses of prostigmine solution have also been used (Pelner and Aibel[39]), as has the use of anti-histamine substances such as histaminase.[37] The new preparation, benadryl, would appear to be worth a trial, although personal experience so far has not been encouraging. Individual attacks may be controlled by intravenous epinephrine (1-400,000 solution) or by placing the hands of the patient in ice-cold water.

TEMPORAL ARTERITIS

Temporal arteritis is a rare disease in which unilateral or bilateral temporal headaches are associated with fever, weakness, anorexia, weight loss, anemia, mild leukocytosis, and the finding of painful tender areas over the scalp and along the course of the temporal vessels (Horton, Brown and Magath[40]). It appears to be a localized arteritis and periarteritis of unknown cause with systemic evidences of infection. There is some resemblance to periarteritis nodosa, but temporal arteritis is self-limited and localized and is a less serious condition. It usually occurs in older people past 60 years of age. Shannon and Solomon[41] have reported a case in which bilateral temporal arteritis was associated with complete loss of vision. The mechanism of the pain here is inflammatory irritation of the temporal arteries and periarterial tissues. Bowers[42] has advocated the use of large doses of thiamine chloride in the treatment, but resection of a small segment of the involved artery is usually necessary.

NEURALGIAS

The neuralgias invade the domain of headache only incidentally. Whereas they are a potent source of facial pain, they infrequently cause pain in and about the head. The two varieties whose manifestations are cranial are the supraorbital and the occipital neuralgias. The former, which may be considered as a subvariety of trigeminal tic, is felt in the distribution of the supraorbital nerve, and the latter involves various posterior cervical nerve trunks, notably the greater occipital. Although actually uncommon as a cause of head pain, the diagnosis of neuralgia is frequently loosely made both by patients who consider almost any type of recurrent pain as a "neuralgia" and by physicians who fail to analyze the character of the pain and its anatomic distribution.

The mechanism of neuralgic pain is poorly understood. Without much supporting evidence, it has been ascribed to pressure on nerves or roots or to hypothetical local changes in the vasa nervorum. Recent work has tended to emphasize the primarily vascular origin of the pain of neuralgia. In a group of patients with trigeminal neuralgia in whom stimulation of trigger points regularly produced paroxysmal pain, Karl, Peabody and Wolff[43] were able to largely eliminate this pain by the administration of vasodilator agents, notably nicotinic acid. They postulated that the pain was the effect of afferent stimuli arising from the trigger area and evoking reflex vasoconstriction involving the trigeminal structures. In discussing atypical facial neuralgias Fay[44] has also emphasized the role of vascular mechanisms.

The pain of neuralgia is characteristically sudden, violent and paroxysmal, usually lasting for a matter of seconds, and is described by the patient as tearing, knife-like, or stabbing. The attacks can often be precipitated by pressure on a trigger area, at the supraorbital foramen in the case of supraorbital neuralgia, and in the lateral cervicooccipital region in occipital neuralgia. In the former condition, the pain is felt in the supraorbital and frontal region, and in the latter it is experienced in the cervicooccipital area with frequent radiation forward to the temple and forehead. There are no objective neurologic findings, and the patient has no complaints between attacks except that occipital neuralgia may be associated with disease of the cervical vertebrae or fibrous structures.

In the treatment of these conditions, medicinal remedies should first be tried, then injections, and finally surgery. The use of nicotinic acid (200 mg. every 4 hours) has been mentioned. Particularly in the supraorbital variety, trichlorethylene, 30 minims inhaled very strongly at hourly or 2-hourly intervals with the patient reclining, should be tried, and Davidoff[45] has reported successful results with the use of large doses of ferrous carbonate. Repeated novocaine infiltration of trigger areas will sometimes break up a vicious cycle and produce cessation of symptoms. Alcohol injections are more likely to bring about prolonged relief but should be used cautiously. In the case of occipital neuralgia any lesions of the cervical vertibrae or musculo-fibrous tissues should be treated, and heat and light massage may be of some aid. If the pains persist in spite of these methods and are severe enough in intensity, surgical measures will have to be undertaken. These include, in order of increasing radicality, excision of a section of the offending nerve-trunk, retro-Gasserian neurectomy, or rhizotomy of the posterior cervical roots depending on the type of neuralgia, mesencephalic tractotomy and prefrontal lobotomy. These latter procedures are to be contemplated only in the case of intractable, long-lasting and incapacitating pain.

DISEASES OF OCULAR, NASAL, AND PARANASAL STRUCTURES

There is no doubt that diseases and disorders of the eyes, nose and sinuses are responsible for many headaches. It is also certainly true that in many cases head pain is falsely imputed to non-existent or unimportant abnormalities of these structures, and that the eyes and sinuses have been held responsible for headaches actually due to other factors. In cases in which the ocular or nasal structures are actually culpable, adequate examination by a specialist in the respective fields will usually reveal without difficulty the structural or functional pathology at fault. When such a cause cannot be found by appropriate methods, and especially when the usually employed remediable measures fail to bring relief, it is time to extend the search to extraocular and extranasal fields and especially to look into the special personality problems and life situation of the patient. In the practice of Davison[46] 36 per cent of his adult patients have primarily functional disorders and in an additional 22 per cent the functional element is of importance. Proetz[47] mentions that only 5 per cent of patients with headache suffer from sinusitis.

In the case of headaches of ocular origin the pain is caused either by irritation of the conjunctival sac, increased intraocular pressure, traction on or irritation of the tissues of the iris, or imbalance of the extraocular muscles. These mechanisms may be associated with such clinical conditions as errors of refraction (hypermetropia, astigmatism, and anomalies of accommodation) and glaucoma It should be mentioned that the ubiquitous "eye strain" often blamed for headaches is a somewhat fictitious entity, and that in the absence of the above abnormalities even prolonged use of the eyes will not cause headache. Ocular headaches, which may vary in intensity from the mildly annoying to the fulminating pain of glaucoma, are felt in and about the eyes, are referred to the distribution of the first division of the trigeminal nerve, and often radiate around the head to the occiput because of induced irritability and tension on the muscles of the scalp and neck. The treatment of headaches of ocular origin is that of the responsible condition.

Headache originating from disease of the nasal structures and paranasal sinuses is due to inflammatory or mechanical involvement of the turbinates, ostia, nasofrontal ducts, and superior nasal spaces. It has been found that the mucosa lining the sinuses is of relatively low sensitivity, while that lining the approaches to the sinuses is more sensitive to pain. Nasal and sinus headache is dull, deep, aching and nonpulsatile in quality. It is felt usually in the frontal and maxillary regions and less often in the occipital region, when it is caused, as in the case of eye headache, by secondary contraction of scalp and neck muscles. The pain of sinus headache seldom becomes as severe as that occurring in febrile states or in migraine. It is characteristically more severe in the morning, diminishing later in the day, except for maxillary sinusitis, in which the pain often begins in the early afternoon and is relieved by recumbency.

Pain of nasal or sinus origin will usually respond promptly, if at times only temporarily, to appropriate rhinologic treatment If a so-called sinus headache is not promptly relieved by cocaine shrinkage or antral puncture, the question of its etiology should be reopened. Anesthetization of the ganglion should relieve the pain of sphenopalatine neuralgia in genuine cases of this somewhat vague syndrome.

Pain due to poor articulation of the temporomandibular joint has been described by Costen[48] and is localized in the vertex and occiput and behind the ears. It may be diagnosed by the presence of malocclusion, by tenderness to internal and external palpation of the joint, and by X-ray examination.

PYREXIAL AND TOXIC HEADACHE

The headache which is a common concomitant of fever or of sepsis or toxic conditions in general has been shown by Sutherland and Wolff[2(b)] to be similar in mechanism to the experimentally-induced histamine headache and to be caused by dilatation of the large intracranial arteries. This headache may be pulsating or dull, deep and aching. It is generalized and is made worse by bodily movement and by coughing. It is relieved by antipyretics and analgesics and disappears with the cure of the underlying disease.

BIBLIOGRAPHY

1. PENFIELD, W., AND MCNAUGHTON, F.: Arch. Neurol. & Psychiat., 1940, **44**, 43.
2. (a) SCHUMACHER, G. A., AND WOLFF, H. G.: Ibid., 1941, **45**, 199; (b) SUTHERLAND, A. M., AND WOLFF, H. G.: Ibid., 1940, **44**, 929; (c) SCHUMACHER, G. A., RAY, B. S., AND WOLFF, H. G.: Ibid., 1940, **44**, 701; (d) WOLFF, H. G.: Ibid., 1943, **50**, 224; (e) KUNKLE, E. C., RAY, B. S., AND WOLFF, H. G.: Bull. New York Acad. Med., 1942, **18**, 400; (f) FRIEDMAN, A. P., BRENNER, C., AND MERRITT, H. H.: Arch. Neurol. & Psychiat., 1945. **54**, 385.
3. VON STORCH, T. J. C.: Ibid., 1940, **44**, 316.
4. FRIEDMAN, A. P., AND BRENNER, C.: Ibid., 1944, **52**, 126.
5. ADAMS, R. D.: Bull. New England M. Center, 1944, **6**, 219.
6. MCKENZIE, W. R.: Dis. Eye, Ear, Nose & Throat, 1941, **1**, 87.
7. HORTON, B. T., AND MACY, D.: M. Clin. North America, July 1946, p. 811.
8. HARRIS, W.: Lancet, 1944, **2**, 654.
9. ALPERS, B. J., AND YASKIN, H. E.: J. Nerv. & Ment. Dis., 1944, **100**, 115.
10. REESE, H. H., AND SHULAK, I. B.: Wisconsin M. J., 1935, 34, 613.
11. DATTNER, cited by REESE and SHULAK.[10]
12. GUTTMAN, S. A.: Arch. Neurol. & Psychiat., 1943, **49**, 556.
13. ALEXANDER, F. (Chicago): Psychosom. Med., 1943, **5**, 205; correction, 1943, **5**, 400.
14. DENNY-BROWN, D.: New England J. Med., 1942, **227**, 771.
15. LEWIS, A.: See ref. 16, p. 607.
16. SYMONDS, C. P., AND LEWIS, A.: Proc. Roy. Soc. Med., 1942, **35**, 601.
17. PENFIELD, W., AND NORCROSS, N. C.: Arch. Neurol. & Psychiat., 1936, **36**, 75.
18. JONES, O. W., JR., AND BROWN, H. A.: J. Nerv. & Ment. Dis., 1944, **99**, 668.
19. KELMAN, H.· Ibid., 1945, **102**, 121.
20. MALONE, J. Y.: J.A.M.A., 1942, **119**, 861.
21. WILSON, S. A. K.: Neurology, Vol. 2. Baltimore: Wood, 1940, p. 1573.
22. ATKINSON, M.: Ann. Int. Med., 1944, **21**, 990.
23. THOMAS, W. A., AND BUTLER, S.: Bull. New York Acad. Med., 1946, **22**, 125.
24. TROWBRIDGE, L. S., CUSHMAN, D., GRAY, M. G, AND MOORE, M.: J. Nerv. & Ment. Dis., 1943, **97**, 509.
25. TROWBRIDGE, L. S., VON STORCH, T. J. C., AND MOORE, M.: New England J. Med., 1942, **227**, 699.
26. HORTON, B. T., PETERS, G. A., AND BLUMENTHAL, L. S.: Proc. Staff Meet., Mayo Clin., 1945, **20**, 241.
27. BLUMENTHAL, L. S.: M. Ann. District of Columbia, **1947**, **16**, **10**.

(*Continued on page 408*)

CLINICO-PATHOLOGIC CONFERENCE

The George Washington University School of Medicine

ROGER M. CHOISSER, M.D., F.A.C.P.

Professor of Pathology, George Washinton University School of Medicine

Case History

A 31-year-old white male was admitted on February 16 and died on May 25.

Present Illness: The patient had frequently noted a stiff, sore neck, lasting from 3 to 7 days after parachute jumping. In September, when jumping, he had had an unusually rough jump and experienced the usual cervical soreness and stiffness but thought little of these symptoms. Approximately 1 week later he developed a shooting pain radiating into the left shoulder and exacerbated by moving his head quickly in any direction or on changing position abruptly. This gradually grew worse, and by mid-October he was unable to lie on his right side or turn over in bed or move his neck in any direction without extreme pain. He also noted about this time that this pain would be reproduced on coughing, sneezing, or on jarring, as in walking. He noted no radiation of pain beyond the shoulder, but in January he developed numbness in the tips of all fingers of the left hand for approximately 1 month. His symptoms then gradually subsided, but he was left with some residual stiffness of the neck and intermittent pain over the left shoulder, and he would be unable to perform any type of activity without increasing his symptoms.

Past History: The patient had always enjoyed good health. He had had the usual childhood diseases without sequelae. Appendectomy had been performed 10 years before. Patient had not had a serious injury prior to the present illness and no venereal disease.

Physical Examination: Physical and neurologic examinations were negative except for the following. He guarded all movements of the neck, but rotation in all directions and lateral flexion were fairly free. On extreme flexion there was some boring pain over the left side of the neck and shoulder which was reproduced by the Valsalva maneuver and upon coughing. There was some tenderness to percussion over the fifth and sixth spinous processes but no radiation of pain. There was no definite muscular atrophy, weakness, or fibrillations. There was slight depression of the brachioradialis reflex on the left, but the remaining deep tendon reflexes were equal. The left abdominal reflexes were consistently depressed. There was slight impairment of sensation to pin prick over the left shoulder, thorax and abdomen, roughly corresponding to C-5 and D-3 to D-12.

Laboratory and X-ray Findings: Routine blood count, urinalysis, malarial smear and Kahn were normal or negative. Spinal fluid analysis revealed total protein of 35.6 mg. and normal cell count and gold curve. Careful spinal fluid manometrics were performed and were found to be within normal limits. X-ray films of the cervical spine, including the obliques and lateral projections, were negative.

Course in Hospital: From February 16 to May 21 this patient appeared to be in a period of remission. He complained very little of pain or disability other than a mild degree of stiffness of the neck. He was characteristically ambulatory. On May 21 the patient reported in the morning that he had severe pain in the neck with radiation into the left shoulder. This pain came on when the patient coughed a few times while attempting to clear his throat. He was examined and found to have a modified Brown-Sequard with paresis of the left arm and leg, more marked in the upper extremity. The condition remained approximately stationary during the day. However, in the evening he developed a practically complete hemiparesis on the left, and an emergency left cervical hemilaminectomy was performed with exploration for a ruptured cervical intervertebral disc. None was found and the patient was removed to his room improved, having regained some motor function on the left. On May 22 a cervical pantopaque myelogram revealed a complete block at the level of the fourth cervical vertebra. Following myelography the patient's condition remained good and the improvement in the hemiparesis persisted. However, in the early morning hours on May 23 the patient suddenly became much worse and developed a practically complete quadriparesis with bilateral intercostal muscular paralysis. He was taken to surgery, and a complete cervical laminectomy was performed. The apparent cause of the block was found and removed. The patient was again improved following surgery, his respirations becoming easier, and there was a return of intercostal breathing on the left and slight return in motor power of both upper and the right lower extremities. However, the patient's respirations were labored, and he was therefore placed in a Drinker respirator. Shortly after surgery the patient's temperature rose to 106° F., but in the following 12 hours fell to 101° F., and the condition otherwise remained essentially stationary. He then began to develop edema of the glottis and mucus in the respiratory tract. His respirations became labored, his temperature again began to climb, and he expired at 7:23 p.m. on May 25.

Clinical Discussion

Senior Bateman: The history of this case shows that the patient was a parachute jumper and that his symptoms of pain and stiffness of the neck were exaggerated after each jump. This indicates that the basic lesion was traumatic. Parachute jumping is a hazardous occupation and can readily result in severe spinal injury, including fracture, dislocation, or both. It is true that the X-ray films revealed neither, yet these may readily be overlooked, especially a subluxation, which may have normal alignment at the time the picture was taken. My second choice was a traumatic rupture of the cervical disc, but this was not found at operation.

Senior Bigge: My impression is that this man had an extramedullary cord tumor and that the trauma from jumping was coincidental. His being a parachute jumper probably focused more attention on it than otherwise would have occurred. I realize the patient had a laminectomy. The first operation was a hemilaminectomy, and the tumor could have very well been missed. At the second operation a complete laminectomy was performed and the apparent cause removed. This could have well been the tumor.

Dr. Bloedorn: Yes, the history says they removed the apparent cause. This leaves us in doubt. They did remove something, of course. It could have been a splintered vertebra, a hematoma, a ruptured disc, and as you say it could have been a neoplasm.

Senior Bigge: My second choice was a ruptured cervical disc, and the reason it was not found at the first operation was that it was at a different level than the surgeon suspected and was missed, but was found and removed at the complete operation.

Senior Chin: My first impression was that of herniation of a cervical nucleus pulposus due to trauma, but there is something that doesn't quite follow. Prior to May 21 the patient complained of little pain and disability and was ambulatory. The spinal fluid manometrics and X-ray films were normal. Following a coughing spell he developed a left hemiparesis and a hemilaminectomy was performed. Following this, complete quadriparesis developed and also a complete block at the level of the fourth cervical vertebra. How would you explain that? Certainly not a ruptured disc. I now favor an extramedullary tumor with compression transverse myelitis.

Dr. Watts: Most of the possibilities have been mentioned. I will speak of a few of the problems and difficulties. The neurologists and neurosurgeons thought this man had a ruptured intervertebral disc. With this I agree. A disc between C_5 and C_6 usually causes pain which goes to the shoulder and subsequently to the thumb. When it lies between C_6 and C_7 it radiates to the index finger and produces a little numbness. In this patient the pain did not go beyond the shoulder and loss of sensation was limited to C_5. A disc could have been present between C_4 and C_5. In hemilaminectomy you usually look for the trouble where you think it is, between C_5 and C_6 or C_6 and C_7. So, it is possible that the disc was one level higher and was not seen. Again a number of disc herniations lie in the midline, and therefore it is possible that in a hemilaminectomy one could not see the protrusion.

Fracture of the neck usually occurs between C_4 and C_5 or C_5 and C_6. It causes a quadriplegia and the majority of patients die within 48 and 72 hours. Respiratory difficulties and fever of 105 to 106° F. occurs with no evidence of infection. The fact that the manometrics were normal on the first examination soon after he entered the hospital, and a complete block shown with Pantopaque after the operation, makes me think that more nucleus tissue was forced into the spinal canal. It seems unlikely that death was due either to infection or hemorrhage.

DR. BLOEDORN: We have here a 31-year-old male whose first complaint was stiffness and soreness of the neck following parachute jumps. Our natural conclusion would be that such trauma was a factor. It may have produced severe strain, dislocation, or fracture of a vertebra, or precipitated rupture of a disc. The physical examination, spinal fluid manometrics and X-ray films did not reveal these. The first operation also failed to disclose the cause. He later developed sudden hemiparesis followed by quadriparesis and a complete block. The common conditions causing complete block could be inflammation, a tubercle, a gumma, or pressure from subluxation; fracture, hematoma, ruptured disc, or, as has been mentioned, a neoplasm. My opinion is that the paresis and block was caused by pressure, either from a ruptured disc or a tumor and between the two I favor a tumor of the cord.

CLINICAL DIAGNOSES

1. Ruptured intervertebral disc
2. Pressure myelitis
3. Edema of glottis, terminal.

ANATOMICAL DIAGNOSES

1. Hemangioma, intradural
2. Multiple intramedullary hemorrhages, cord C_2–C_6
3. Edema of larynx with terminal edema of lungs.

DISCUSSION

DR. CHOISSER: The patient was not considered to be acutely ill until he suddenly developed the hemiparesis following a coughing spell. Then a diagnosis of ruptured intervertebral disc was made. At the second operation the dura was opened and an extramedullary hemangioma was found and removed. The hemangioma was at the level of C_3 and C_4 and produced the neurologic symptoms. The general necropsy findings were completely negative except for edema of the brain and cord with multiple purpuric hemorrhages into the cord which were believed to be due to the surgical trauma of the laminectomy. The severe edema of the glottis and lungs was considered to be terminal, resulting from the cord block with interruption of nerve impulses to these structures.

President's Page

AMA'S POLICY-MAKING BODY

Although I have long been active in the affairs of our Medical Society, I had never attended a session of the AMA's House of Delegates until its recent meeting in Atlantic City. It seemed to me that before I assumed the responsibilities of President, it might be a helpful and enlightening experience. I am glad to say that it proved to be just that.

After attending sessions of the House I came to the conclusion that it is a more progressive body than I had thought. Whatever its past record in regard to controversial medical issues, the views I heard expressed were for the most part anything but reactionary. The attitude of this representative body of physicians seemed to be that problems confronting them must be dealt with realistically. This was particularly true when the wider distribution of medical care came under discussion.

I was also struck by the fact that most matters discussed were the same as those which face state and county medical societies. It was apparent that if these organizations are ineffective in dealing with their problems, the AMA itself will be impotent. I came away, therefore, with the conviction that our Medical Society, in common with others throughout the country, must exercise greater effort if the AMA's hand is to be strengthened.

As to the AMA leaders, I was particularly well impressed by Dr. Edward L. Bortz, the Association's new President. He is a man of vision and unusual ability. Every member should read his message to the House which appeared in the June 14 issue of the *Journal of the American Medical Association*. Dr. Bortz outlined in a clear and convincing manner what I think is a splendid program.

There is no need for me to be more specific in regard to the various matters which came before the House. Its proceedings will be published in the *Journal of the AMA*. Our delegates to the AMA, Drs. C. B. Conklin and Herbert P. Ramsey, will also present their report in the MEDICAL ANNALS.

There is one more matter, however, which I wish to mention. This year for the first time in several years, officers of state societies were excluded from executive sessions of the House. The reason given was that in the past confidential information had leaked out to the newspapers. I was not impressed by this explanation and hope that in the future this situation will not recur, as, in my opinion, the barring of officers of state societies, or, as a matter of fact, of any Fellow of the Association from these sessions, is not in keeping with the democratic spirit of the Association and does not improve medical relations.

Before I conclude my first message, I wish to say again that I am counting on the support of all our members to make this year one of accomplishment and progress.

Raymond I. Holden

Editorials

RAYMOND THOMAS HOLDEN, JR., M.D., F.A.C.S.

Dr. Raymond Thomas Holden, Jr., 81st President of the Medical Society of the District of Columbia, like his two immediate predecessors, is a native Washingtonian. He is also the son of a distinguished Washington physician, the late Dr. Raymond T. Holden, Sr., who was described by Dr. John B. Nichols in the June number of the MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA as "the beloved family physician of tradition and story." Dr. Holden's mother, the former Celeste S. Moritz, who survives her husband, takes pleasure in the successes of her able son.

Dr. Holden was born April 11, 1904. He received his early education in the District schools, graduating from Central High School in 1922. He obtained his premedical training at the University of Notre Dame (1922–1924), and received his degree of Doctor of Medicine from Georgetown University School of Medicine in 1928. Internship at Providence Hospital, Washington, and a residency at Columbia Hospital for Women, Washington, followed.

Dr. Holden entered private practice in 1930, specializing in obstetrics and gynecology. In the years that followed, he became a Diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Surgeons, and a member of the Georgetown Clinical Society and the Washington Gynecological Society.

Undoubtedly, Dr. Holden is one of the youngest physicians ever to hold high office in the Medical Society. He became a member of its Executive Committee in 1936, serving until 1939, when the Committee was reorganized and became known as the Executive Board, whereupon he was elected again for a four-year term. In 1942 he resigned to enter the U. S. Navy.

Commissioned Lieutenant Commander, U. S. Naval Reserve, on January 29, 1942, Dr. Holden was assigned to active duty at the Naval Dispensary, Washington, D. C. in February 1942. In July 1943 he became Senior Medical Officer, U. S. Advanced Amphibious Base, Falmouth, Cornwall, England, where he remained until November 1944, when he became a member of the Medical Officer Staff of Commander, Amphibious Bases, United Kingdom. He returned to the United States in August 1945 to take charge of the U. S. Naval Dispensary, Cleveland, Ohio, completing his service at the U. S. Navy Communications Annex in Washington in February 1946.

Dr. Holden took an active part in the preparations for the Normandy landings, for which he received the Navy Commendation Ribbon. He won several promotions and was discharged as a Captain in the U. S. Naval Reserve. He is Clinical Professor of Obstetrics and Gynecology at Georgetown University School of Medicine, and is on the active medical staffs of Providence, Columbia, Georgetown and Doctors hospitals.

Dr. Holden lives with his 14-year-old daughter, Molly, at 3111 16th Street, N.W.

Few physicians have become President of the Society who are better equipped for the responsibilities than is Dr. Holden. His long experience as a member of boards and committees of the Society has made him thoroughly familiar with the Society's affairs. In critical times such as these, the Society is fortunate in having at its head a man of Dr. Holden's background and capabilities.

Known to his friends as "Ray," Dr. Holden is a quiet, likable man of strong convictions. He is intensely loyal to his friends and has a strong sense of obligation. Members can therefore be assured that Dr. Holden will give sound leadership to the Society in the coming year.

RAYMOND THOMAS HOLDEN, JR., M.D., F.A.C.S.

President, The Medical Society of the District of Columbia, 1947–1948

DANGEROUS DRUGS BRING NEW RESPONSIBILITIES*

A study of the prescription files of our older pharmacies reveals some startling changes in the materia medica. While practitioners of medicine and pharmacy have been conscious of these changes in a general way, it is only by the perusal of the files of establishments which have been compounding physicians' prescriptions for thirty years or more that one can make comparisons and really visualize the contrast between what the doctor "wrote for" in the early years of the present century and what is being prescribed today.

Liquid mixtures containing tinctures, fluid extracts, and elixirs incorporating such old standbys as strychnine, arsenic, iodides, bromides, salicylates and iron compounds; capsules containing mixtures of four or five powdered vegetable or chemical drugs; and pills incorporating mixtures of laxative and tonic drugs do not constitute a large percentage of the total number of prescriptions compounded today. And powders in papers "to be placed on the tongue and swallowed with water" are passing from the scene rapidly.

Modern dosage forms of drugs are largely the tablet, the clear or emulsified elegant type of liquid medicine, and the solution for injection supplied in individual ampuls, sterile and ready for use by the parenteral route.

Of course, ointments nicely put up in collapsible tubes, and perhaps less frequently in tins or jars, suppositories and emulsified lotions, nose drops and other preparations are freely prescribed for external application and use in the body orifices. But here again one notes a change, for the greasy wool fat and petrolatum have been replaced to some extent with "washable" bases.

As for the composition of the medicaments themselves, only the pharmacists, pharmaceutical chemists, the biochemists, the pharmacologists and the hundreds of research specialists are fully aware of the tremendous strides that have been made in recent decades to eliminate uncertainty of composition, to provide standardized dosage forms, and to meet the hazards of administration of highly potent drugs.

In the past when we dealt with relatively simple drugs, there grew up a kind of unwritten agreement between the prescriber and the dispenser of medicines as to how prescriptions were to be handled. Relations between physicians and pharmacists have not been the subject of much legal definition. The professional practice acts covering medicine and pharmacy define the respective limitations of lawful activity, but very few state or Federal laws define the term "prescription," and none go into very much detail as to how medicines shall reach the patient after the physician prescribes. This is all largely a matter of custom which has been controlled almost subconsciously by the provisions of the codes of ethics of medicine and pharmacy, by the ingrained respect of the professions for each other, and by the common bond of interest in the welfare of the sick.

The very rapid progress in scientific medicine which has brought us an equally rapid development of more specific therapeutic agents designed to overcome various functional deficiencies has also introduced certain dangers to the patient which require recognition and careful consideration by both professions.

Medicine and pharmacy have been directed by the Federal Government to warn patients against possible habit-forming effects of barbiturates, under certain conditions. More recently certain sections of the Food, Drug and Cosmetic Act have been interpreted to require warnings on prescription labels pointing out that resistance to infection may be lowered when thiouracil is administered.

It is the Government's contention that patients must be guarded not only against the possible harmful effects of certain potent drugs but also against the physician who may neglect to warn his patient of these possible effects. It is proposed to compel the pharmacist, under penalty of law, to place warnings on the labels of certain prescriptions whether the physician wants the warning to appear on the label or not.

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*This is the seventeenth in a series of guest editorials by distinguished physicians and laymen.

While this applies to very few drugs at present, it is an indication of how the rigid and respected custom, developed over the years, of having the physician write the prescription, which includes the signa or directions to the patient, and having the pharmacist follow it implicitly, is being tampered with.

Certainly, no member of the medical or of the pharmaceutical profession has any desire to withhold any safety device which is designed to preserve human life. But it is difficult to conceive that a physician would use or prescribe a new drug having highly dangerous as well as curative potentialities without keeping the patient under strict observation and warning him, in his own way, against possible unfavorable reactions. If new drugs released by the Food and Drug Administration are so dangerous as to require warning the patient against them, over the doctor's head, it would seem that they should be released only for use while the patient is hospitalized or otherwise under constant observation.

As long as we have professional practice acts regulating admission to the practice of medicine and pharmacy and as long as the professions enforce codes of ethics which impose rules of conduct upon their members that are much more stringent than any legal requirement, it would seem that the professions can well be trusted to work out, between them, adequate safeguards for the patient.

It is difficult to believe that the Congress of the United States ever intended to by-pass the physician in determining what information should be given to the patient about the medicine he has prescribed. Pharmacists do not want to be placed in the position of being compelled to write directions on a prescription which the doctor has not ordered.

Perhaps the time has come for both professions to examine more closely their several and joint responsibilities in the prescribing and dispensing of drugs known to have inherent dangers for the patient. It may be that the customs and understandings of the past, which apparently made specific law and regulations on the subject unnecessary, require revision, or the formulation of a new understanding, more in keeping with the swift progress of medical and pharmaceutical science. It is unthinkable that the professions will stand idly by while the prescription written by the physician for his patient is subject to change without notice, in the matter of directions, and the long arm of the law is to guide the pharmacist's hand in writing the label as the Government thinks the doctor should have written it.

ROBERT P. FISCHELIS, *Secretary,*
American Pharmaceutical Association

REHABILITATION SERVICE SEEKS PHYSICIANS

The District of Columbia Rehabilitation Service is in the process of establishing a list of participating physicians licensed to practice in the District of Columbia who may be available for the purpose of providing general physical and specialty examinations as well as treatment to applicants of this Service. This list would be used in those cases where applicants have no physicians of their own. Physicians desiring to be included on this list should fill out an "Information on Professional Qualification" form which is being mailed to all physicians licensed to practice in the District of Columbia.

The primary objective of this program is to restore to remunerative employment persons with disabilities constituting vocational handicaps. As a necessary step in evaluating the individual's eligibility and his specific vocational rehabilitation needs, each applicant is required to undergo a general physical examination and such specialist examinations as are deemed necessary, except in those instances where recent medical reports on the individual applicant are available. Each physician is reimbursed for the services authorized and rendered in accordance with the established Fee Schedule of the District of Columbia Rehabilitation Service.

The program of the District of Columbia Rehabilitation Service, Office of Vocational Rehabilitation, Federal Security Agency, has been in existence since 1929. It was established by Congress as a public program looking to the restoration of disabled civilians to suitable employment.

The following services are available to disabled persons who are eligible under the program of the District of Columbia Rehabilitation Service:

Physical and vocational diagnoses to determine the extent of disability, occupational limitations, and vocational capacities and skills.

Physical restoration, including prosthetic appliances, to remedy or remove a disability, providing such applicants can establish that they are financially unable to pay for these services.

Vocational counselling and guidance to aid disabled persons to return to their previous employment or select a new and more suitable field of work compatible with their disabilities.

All forms of vocational and educational training to equip disabled persons with occupational skills.

Maintenance during rehabilitation, providing such applicants can establish that they are financially unable to maintain themselves.

Placement in a suitable employment to safeguard handicapped workers and assure proper utilization of their abilities and skills.

Follow-up on performance in employment to assure successful adjustment.

W. O.

THE DILEMMA OF THE EPILEPTIC CHILD

Although epileptic children far outnumber victims of poliomyelitis and there are as many epileptics as have diabetes or advanced tuberculosis, far too long they have been the "forgotten children." Treated as pariahs and rejected by schools, disrupting to other children in their families, often they are emotionally disturbed and scholastically held back because of their seizures. Literally they have had no place to go, except for the public institutions for defectives or psychotics where the great majority of them do not really belong. Last year in the District of Columbia there were 350 calls for placement of epileptic children, with physicians and families alike at a loss as to where to send them.

Realizing the magnitude and poignancy of the problem a group of physicians and laymen in Washington and Baltimore have banded together to form the Maryland-District of Columbia Association for the Control of Epilepsy. The organization's immediate program is the taking over and enlargement of the Eric Bowditch Memorial School, Brunswick Park, Ruxton, Maryland, the only school of its kind on the eastern seaboard, and running it on a non-profit basis. Here both paying and non-paying epileptics, aged six to eighteen years, and of normal mental ity, not only are given the benefits of modern medication, that bring the seizures of 80 per cent of all patients under complete control and effects partial control in others, but are educated and emotionally fitted to take their places in the community. Ultimately it is hoped that the school will serve as a demonstration center of what should and can be done, medically, educationally, psychologically and socially for the epileptic child; that it become to epilepsy what Warm Springs is to poliomyelitis. At present a mere handful of 25 children benefit by the school; but with sufficient paying pupils and endowment funds for increased personnel and facilities, existing buildings and thirty acres of grounds could easily accommodate hundreds more.

A secondary objective of the Association is to raise funds to be donated to the Children's Hospital in Washington and the Harriet Lane Division of Johns Hopkins Hospital in Baltimore for research in the etiology and therapy of epilepsy. Also, the Association, strategically located as it is in the Capital, intends to act as a pressure group for the revision and improvement of much existing legislation that pertains to epileptics. At present many unjustifiable and obsolete laws, such as those interfering with employment or marriage, stand on the books.

Physicians who have epileptic children of normal mentality as patients are urged to refer cases to the school, whose director is Dr. Henry L. Bowditch. Dr. Bowditch will also be glad to give information on the most recent and effective therapies. In Washington, Dr. Joseph W. Stein is also available as a source of information.

The need to control seizures and to fit children for leading a normal life in a normal environment once their seizures are controlled is a pressing one. The Maryland-D. C. Association for the Control of Epilepsy is an established agency through which local physicians can learn and work effectively. It merits the support of all physicians and laymen directly or indirectly concerned with the problem of epilepsy.

EDITH M. STERN

WHEN THE GENERATIVE SYSTEM WAS TABOO

That genial philosopher and physician, Dr. Edward L. Keyes, once commented, "If the social hygiene movement had done nothing more than to make the diagnosis and treatment of venereal disease respectable, it still could be credited with a great achievement." Medical literature of the late nineteenth and early twentieth century attests the truth of his observation.

When, for example, Dr. William Niles Wishard, noted Hoosier physician and hospital administrator of the 1880's, went through the wards of his city hospital, he was much impressed by the general neglect of patients suffering from genitourinary ailments. As the Indiana Health Department's *Monthly Bulletin* (April 1947) says, "No doctor [of those days] wished to be identified with surgery and medical treatment of such a sort. Each was afraid that his regular patients would not wish to be known as patrons of a physician specializing in, or even having anything to do with such a practice." Dr. Wishard, with characteristic courage, decided to specialize in the genitourinary field and, when friends tried to dissuade him from the rash decision, he declared, "Since the specialty, at this time, cannot reflect honor on me, I shall try to reflect honor on it." Proving that "it is safer to be a man than a mouse, he became one of the most universally respected physicians of his time," adds the *Bulletin*.

Perhaps the most delightful tome regarding medical practice of that Victorian era is the quaintly fashioned one written in 1882 by Dr. D. W. Cathell, well-known practitioner and teacher. Those familiar with the volume know that, from its title page, "The Physician Himself and What He Should Add to the Strictly Scientific," right through to the closing paragraph, it is laden with gems of advice that illuminate the medical mores and folkways of the period. The final admonition is worthy of Bunyan. It is a most pessimistic valedictory. Writes Dr. Cathell, "The truth is, when a doctor dies, his family is usually left poor and helpless, unless he has acquired money otherwise than by practice. Were you to practice for thirty years without losing a single day, and collect eight dollars every day of your life, you would receive but $87,600. Deduct from that amount your expenses for yourself and your family, your horses, your carriages, your books, your instruments, your taxes, and a multitude of other items for the whole thirty years, and then so far from being rich after so long and lucky a career, you would have but little, very little left to support you in your old age after a whole lifetime of anxiety, responsibility and usefulness."

But a far direr fate was in store for the misguided physician who dabbled with that "old debbil," venereal disease. Of these afflictions Dr. Cathell warned, "Gonorrhoeal and syphilitic cases are not especially desirable on any account, except for the fees they bring; they are dirty secret cases and rather repel than attract their victims and their friends, from the doctor who attends them when they require a physician for other diseases. Attending them will, however, often enable you to pick up a handsome cash office-fee.

"Take care that your reputation for attending venereal diseases does not overshadow or eclipse other kinds and give you the title of 'P—x Doctor,' and entail the social ostracism and loss of family practice that would follow,—or that extra success in restoring the menses, in females who suspect pregnancy, does not bring you an extra number of such cases and give you the title of 'Abortionist,' —or that attending an excessive proportion of courtezans or bruisers does not give you the name of having a 'Fancy Practice.' "

Today the treatment of syphilis and gonorrhea can acclaim its host of expert urologists, syphilologists, and laboratorians; its excellent societies and literature; its marvels in the drug and antibiotic fields; and the widespread public education via radio, press and lectures. But we still have sort of a kindred feeling for those early venereal disease practitioners who were looked on as black sheep, not merely by the public but also by many of their professional confrères. For it was only about twenty-five years ago when we were in the same boat. We had been trying to persuade the executive of a nationwide child-health organization to devote some attention to congenital syphilis and gonorrheal ophthalmia. In dismay and disgust she finally snapped out, "What do you expect us to do?—tie your nasty diseases up to our nice ones!"

Ray H. Everett
Executive Secretary, Social Hygiene Society of the District of Columbia

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, June 23, 1947, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

Active Members

Reginald A. Cutting, 1247 New Hampshire Avenue, N.W.
Julius D. Damian, 2700 Que Street, N.W.
Carlos A. Dominguez, 1835 Eye Street, N.W.
Henry L. Feffer, 1918 K Street, N.W.
Arnold H. Gould, 1835 Eye Street, N.W.
Ernest A. Gould, 1744 N Street, N.W.
Edwin P. Hall, 2025 Eye Street, N.W.
Samuel P. Hicks, Georgetown University School of Medicine
Merwin L. Hummel, 4715 Fulton Street, N.W.
Stanley W. Kirstein, 1835 Eye Street, N.W.
Jacob S. Light, 2529 Pennsylvania Avenue, N.W.
Eugene J. McDonald, 1801 Eye Street, N.W.
Henry Joseph Myers, Saint Elizabeths Hospital
Herbert L. Phillips, Room 217, Union Station
John W. Price, 643 F Street, N.W.
Frederick W. Schneider, 500 G Street, N.E.
Irving Schulan, 1328 Eye Street, N.W.
Jefferson J. B. Sebastian, 1917 Eye Street, N.W.
Gordon M. Smith, Gallinger Municipal Hospital
Joseph H. Watson, 1822 Biltmore Street, N.W.
Jonathan M. Williams, 1801 K Street, N.W.

Associate Member

John Failor Brownsberger, Washington Sanitarium, Takoma Park, D. C.

HONORING THE FIFTY-YEAR MEN IN MEDICINE

HAROLD M. CAMP, M.D.

Editor, Illinois Medical Journal

EDITOR'S NOTE: Dr. Camp is a medical editor of wide experience. With the exception of the *New England Journal of Medicine* and the *New York State Journal of Medicine*, his publication has the largest circulation of any state medical journal. His editorial duties are therefore heavier than those of most medical editors. In consequence, his interests encompass a wide variety of subjects of which the following is an example.

To merely list the activities of the state medical societies today would require more space than is available in the average medical journal, for in recent years these many activities have increased so extensively. We are all interested in the major projects as approved by all societies such as prepayment medical care plans whether in the form of medical service or cash indemnity, for we realize that the widest possible coverage for those in relatively low income groups is highly desirable. The Illinois State Medical Society, like all other similar organizations, has given serious consideration to this as well as many other present-day problems. A complete list of all official committees elected or appointed each year in this Society would fill five or six pages of letterhead size stationery.

For years we have seen a few special meetings of component societies held to honor some physician who has completed fifty or more years in practice. These meetings have created more than the usual interest among the membership. In 1937 the Illinois State Medical Society gave serious consideration to the formation of a Fifty Year Club, and the desirability of issuing a suitable certificate and emblem to those members who have given their services to the people of their respective communities over this long period of time.

Later that year, the Fifty Year Club was formed; a committee of three was named to be known as The Fifty Year Club Committee, and suitable certificates were prepared and emblems ordered. The first recipient of a certificate and emblem was a physician then past the age of 90 who had been in active practice 65 years. A special meeting was held in his home community, and although there were actually 25 physicians practicing in the county, all members of the county medical society, there were more than 150 present at this special meeting honoring this elderly physician.

During the year 1938 all physicians who were members of this Society and who had practiced fifty years or more were admitted to the Fifty Year Club. In some instances physicians outside the county society membership who were recommended by the local society for this honor were likewise admitted.

Each year at the annual meeting of this State Medical Society, a Fifty Year Club luncheon meeting is held, and invitations extended to all members to be the guests of the State Society at this function. The attendance has always been large. At the 1947 annual meeting held during May 1947, 102 were present at the annual luncheon meeting.

Since the Club was first organized, there have been more than 515 certificates and emblems presented to the fifty-year men in medicine, and approximately 325 are living at this time. The oldest member in years of service is a physician who is just completing 69 years of practice, and he is still quite active in his daily work. Many of the members of the Fifty Year Club are physicians with national and international reputations. The club has no dues, there are no by-laws, and they get together once each year, but this is indeed a gala event, and many of them come to the annual meeting because they desire to attend the luncheon meeting.

It is the usual custom for county societies to hold a special meeting to honor the men who have recently completed fifty years in practice. The attendance is invariably good, and the presentation is usually made by the Councilor for the district in which the physician resides. All certificates and emblems are sent to the Councilor from the office of the State Society secretary, the certificate being appropriately framed. The emblem is a gold enameled lapel button with the inscription, "Illinois State Medical Society; Fifty Year Club." For the women members a pin of similar type is presented.

Occasionally a physician who is bedfast and who has completed fifty years of service is presented his certificate and emblem in his own home, the presentation usually being made by the Councilor for that district.

The Illinois State Medical Society has endeavored to get a photograph of each member of the Fifty Year Club, these being retained in the extensive collection of photographs with appropriate biographic data, permanently filed in the Illinois State Historical Society Library in Springfield. The Chairman of the Fifty Year Club Committee and the other members of his committee are all members of his club, and all active in practice today even though all of them have been in active practice for 54 years or more.

There has probably been no development within this Society in recent years which has been of greater interest and has met with more popular appeal than the formation of this Club and the honoring of those men and women who have completed fifty years of practice. When the Fifty Year Club was first organized, it was the general opinion of the membership that it was time to give consideration to the physicians individually, a matter previously overlooked, as is the case in most societies today.

Photographs of those attending the Fifty Year Club Luncheon will be published in an early issue of the *Illinois Medical Journal*, and those of you who see this copy can determine for yourselves whether or not this project to honor elderly physicians is a desirable one.

"CALL ON SOME DOCTORS, SON. . ."

The apple-cheeked investment salesman, freshly weaned from college, sets forth in the world with two pieces of equipment, a brief case for that dignified look, and some sound advice from his elders.

The old-timers in stocks and bonds slap him on the back and give him the advice they had when they were young:

"Go call on some doctors, son."

It is sound advice. Doctors, too often, are good prospects for blue-sky investments. When it comes to slick trading in securities, they haven't the time to investigate. They're scientists, analysts of human ailments, artists of the operating room, travelers in the night, worriers, dreamers, thinkers and curers. But not financiers.

Diagnose an illness? Sure. But when a thousand dollars could be made or lost on a one-point change in Giltedge Preferred, they're busy; a child's appendix has ruptured.

Buy the best X-ray machine at the right price? Probably. But skillfully manipulate industrial investments to put their children through college? Or to take care of the family when the old ears are not so sharply attuned to the stethoscope, hands not so sure on the scalpel? Not very often.

A doctor is a busy man and a hopeful one—hopeful that the fees will take care of the future. True, some doctors are wealthy, or near it. To most, wealth is just something someone else enjoys. But many doctors, lulled by the crowded waiting rooms which went hand-in-hand with the war-born doctor shortage, figure they'll be pretty well set for retirement, the way fees are piling up.

Yes, the doctor needs a "bullet-proof" investment, and the United States has provided it in Savings Bonds. We all know that, but just to make it available isn't enough.

Most doctors need something more. In business matters they need a string tied around a finger. The Government is offering this to them in the new Bond-a-Month Plan. Your bank ties the string, gives it a yank every month. And all the doctor has to do is leave it there. Wilson Mizner said: "The gent who wakes up and finds himself a success hasn't been asleep." As to planning his future, once the doctor has invested in Bond-a-Month, he can give all his attention to his important work.

Before getting down to what the Bond-a-Month Plan can do for the non-salaried doctor, let's take a look at some of the facts in the case of the average practitioner. He's busy, more of late than ever before. His routine is hospital calls, perhaps an operation or two, office hours, house calls, office records, telephoning, more calls after dinner. Every so often a baby fails to realize the doctor has a schedule, or someone breaks a leg, or gets measles. Even the specialists work no 9-to-5 day.

The U. S. Department of Commerce has made studies of doctors' incomes, based on reports of a sample of the 129,000 men and women in private practice in 1940. The studies show that the income rises slowly to a maximum in the early 50's and then starts dropping. From 35 to 54 is the real money-making period.

At 35, most doctors have begun to pay off their starting-in-business debts, have built up a small neighborhood practice and are becoming known. Their practice grows with ability. By the time they are 54, other doctors, young and vigorous, have come in with new methods, machines, theories. They make inroads into the established practice of the veteran. The older man no longer so willingly drives out into the country on sick calls. Office hours are shaved a little at the start and the end of the day. There are fewer operations.

And somehow, without the doctor's really knowing why, the bank balance doesn't hold up the way it used to.

To come as close as we can to keeping the horse in front of the cart, let's see what Bond-a-Month will do and then explain why this is the solution to the doctor's problem of saving for future security.

Bond-a-Month opens systematic saving through Government bonds to anyone with income and a checking account in a bank. Until now this was available only through Payroll Savings. It operates this way:

The depositor who wishes to buy a bond each month signs a card authorizing the bank to deduct the purchase price from his checking account. The bank issues the bonds and delivers them to the customer monthly. The periodic bank statement shows payment for the bonds.

And from the first and the only time the doctor signs his authorization card, he has nothing else to do except open the envelopes the bank sends him with the bonds inside.

What does the doctor need?

1. He needs some sort of arrangement for his financial future because, according to studies of his profession, incomes of physicians are much more responsive to change in the national income than are the incomes in other professions. If the national income drops and patients no longer can afford to call on the doctor so often or to pay him as quickly, a doctor's bankbook will feel the change.

2. In most instances, the doctor has no social security or pension to fall back on. Thus, he needs something to serve as an old-age reserve.

3. He needs simplicity—an arrangement which does not call for continual checking, manipulating, buying and selling.

4. He needs safety. He cannot afford to take the risks which must be protected by constant market vigilance, by buying and selling strategically.

A savings bond plan should be the foundation upon which the doctor builds his security. There is no safer investment in the world than Savings Bonds. There is no riskless investment which pays such a guaranteed return.

Consider:

If you invest monthly under the Bond-a-Month Plan	*In five years you will have*	*In ten years you will have*
$37.50	$2,319.00	$4,998.00
75.00	4,638.00	9,996.00
150.00	9,276.00	19,992.00
300.00	18,552.00	39,984.00

Here, for the doctor himself, are vitamins E, F and G, thoroughly tested and always compounded with interest. These "vitamins" ease common symptoms of post-middle age such as chronic worry and doubt. They are available at a bank near you And with millions of current users, we can make this unusual guarantee: one and a third times your money back if you are satisfied.

WHAT IS THE SOLUTION OF THE NURSING PROBLEM?*

James A. Gannon, M.D., F.A.C.S.
Washington

May I acknowledge here and at this time my high regard for the Graduate Nurses' Association and for the excellent job it has done to improve nursing education. I approach the subject, "What is the solution of the nursing problem?" with a good deal of humility and with a realization that I am ignorant of many of the technical details concerning nursing education. A spectator at a baseball game frequently does not see eye to eye with the umpire, and he exercises the great democratic privilege of free speech by vocalizing his disagreement. Although he is not a baseball player himself, he has an over-all picture from his point of observation, and his opinion is sometimes not without value.

The nursing problem is related to the shortage of nurses which exists at the present time. The causes which brought this shortage about include particularly the comparatively recent increased opportunities for the employment of young women in many fields. The war further increased these opportunities in munitions plants, business, and government, and drained not only candidates for nurses' training schools, but also candidates for the teaching profession and others. In recent years high school graduates have been able to obtain employment at once with remuneration which exceeded that earned by veteran nurses and teachers. The returning soldiers are supplying the manpower for industry, and many of the women will soon return to the kitchen, the nursery, the training schools, the teaching profession, and the other occupations which have for a long time offered opportunities to women. I think we can now look for some increase in the candidates for nurses' training schools because of this reason.

I have been an interested observer of nursing education for more than thirty-five years, and I have seen the standards raised higher and higher until the graduates of a training school have obtained what is almost the equivalent of a college education. You will forgive a personal observation. In 1914 I was appointed Chief of Staff at the Washington Asylum Hospital, which became Gallinger Municipal Hospital before I resigned in 1928. In 1912 there was a small struggling training school in the institution known as the "Capital City Training School for Nurses." I automatically became Dean of this School. Largely due to the advice and directives of the Graduate Nurses' Association, this puny school grew into the flourishing, respected, excellent institution which it has now become. Regular inspections were made by the Graduate Nurses' Association. and under pain of non-recognition by the Nursing State Boards, the authorities of the District of Columbia were persuaded to make many changes regarding housing, recreation, hours of service, and curriculum. I am sure that the influence of the Graduate Nurses' Association caused hundreds of schools throughout the country to make similar improvements. The graduate nurses today reflect credit on their training schools. The Graduate Nurses' Association should be proud of their handiwork.

I am now approaching dangerous ground. I do not expect all nursing educators to agree with what I am about to say. Nursing education has gone too far if the object of that education is to prepare women for bedside nursing. Too much time is spent in the classroom in proportion to the time spent in the wards. I do not see the possible use of training nurses regarding the intricacies and minor details of anatomy, physiology, chemistry, histology, pathology, and materia medica. She will never have an opportunity to use a microscope at the bedside. When she graduates she is capable of administering intravenous medication, hypodermoclysis; inserting the Wangensteen and Miller-Abbott tubes; and in a pinch, administering anesthesia. She has a fair idea of the interpretation of X-ray films. Some can do microscopical blood examinations. The graduate nurse, then, has become a "little doctor" without recognition and without opportunity to apply her knowledge. She is unhappy and dissatisfied. She is bored with the routine of home nursing. Feeding patients, bathing patients and disposing of their excretions and performing all the routine and unexciting tasks which

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*Read before the Society, May 7, 1947.

Calendar of Meetings

June 3	Association of Undergraduate and Practical Nurses
June 10	D. C. Dental Society
June 14	Washington-Baltimore Psychoanalytic Society
June 16	Program Committee, Annual Scientific Assembly Social Affairs Committee, A.S.A.
June 20	Board of Censors Washington Metropolitan Health Council
June 23	Executive Board Graduate Nurses' Association
June 26	Grievance Committee
June 27	Section on Neurology and Psychiatry Washington Metropolitan Health Council
June 30	Washington Gynecological Society

constitute bedside nursing do not appeal to her. She has been educated beyond these things. Bedside nursing to her has become a menial occupation. The financial rewards do not justify all the study and preparation which have gone before. She is not to be blamed for this attitude. Her life's work, then, must be as a supervisor, a teacher of nursing, an officer in the Army, Navy, or Veterans' Bureau, an official in an industrial plant, or some other important occupation which carries with it commensurate remuneration and social security.

When she discontinues bedside nursing, her place must be filled. Her logical successor is the practical or undergraduate nurse, whose future education is now the concern of the Graduate Nurses' Association and of all of us. Like the spectator at the baseball game, I have the following suggestions to make. Let a high school certificate, good health, and good moral character be the ticket of admission to any training school. Revise the curriculum so that the student can learn to be a good bedside nurse in two years. At the end of this time, issue certificates of practical nursing to those whose circumstances and desires require these certificates. To those whose aspirations and circumstances fit them for higher positions in the nursing world, provide another year, or maybe two, of education and at the end of that time give them certificates which proclaim them to be graduate nurses. The six-month probationary period which is now devoted solely to didactic teaching would be too long. This should not exceed two months. Charging fees for tuition eliminates many promising young women. I think that the hospitals should allow the students a small stipend each month in return for the cheap labor which the hospital obtains while they are in training. This stipend should be sufficient for carfare, stockings and other personal articles. When the graduate and undergraduate meet in the hospital or in the home, the graduate should be the superior and should direct the undergraduate. The fees charged by each must be regulated by the Graduate Nurses' Association.

At this time, the hospitals are crowded to the limit. Many hospital wards are closed because of lack of nursing personnel. I think the personnel will be provided if the suggestions I have offered can be acted upon formally. I think that the medical profession must share the responsibility for the present crowded conditions of hospitals. We have trained our patients to go to the hospital on slight provocation. Of course, it is more convenient to the doctor to call on six or eight patients in the same hospital and complete his morning's work in an hour and a half where the same number of calls would take most of his day otherwise. Parking the car has become a serious problem. Mothers have been delivered at home for centuries, and they could still be delivered at home with safety, but it is more convenient for the obstetrician to deliver them at the hospital. Most people have hospital insurance and ask to be sent there in case of any illness. Crowding of homes and lack of domestic help make this necessary. Since the insurance company is paying the bill, many patients may remain several days longer than they would if they were paying the hospital bill. The doctor should discourage this practice. Hospital overcrowding complicates the nursing problem. I believe that the medical profession should take more interest in nursing education and that we should have many more meetings like this one tonight where there can be an exchange of ideas which should result in benefit to the sick—which after all is the goal of both the nursing and the medical professions.

AN APPREHENSION IN 1941 COME TRUE IN 1946*

FRANK H. LAHEY, M.D., F.A.C.S.

Director, The Lahey Clinic

EDITOR'S NOTE: Dr. Lahey's statement is of particular interest, not only because of the subject matter but because many of his views coincide with those presented by Dr. James A. Gannon, author of the preceding paper.

THE NURSING SITUATION

["As I have observed the changes in medicine from time to time, I have been increasingly apprehensive concerning the nursing situation. I am highly conscious of the fact that criticisms of some of the present trends in nursing may meet with far from approving reactions on the part of the nursing profession. Since I speak as one in daily contact with the nursing problem at the bedside, in an executive capacity and in its specialized branches, I am at least qualified by experience to make some observations concerning it. I have been fearful for a number of years that the trend in nursing is away from service to the patient and too much in the direction of higher education. I have been fearful lest the higher and higher standards of requirements for entrance and graduation in nursing might not make it more and more difficult to obtain a sufficient number of nurses to meet our increasing demands. This is an apprehension which our present situation as relates to nurse shortage indicates as being more and more justifiable. What with the demands made on nursing at the present by army service, by public health, by industry and by other special branches in nursing, together with the relatively high cost of nursing for patients, it is necessary for nurses, physicians and legislators to have in mind at least the possibility of the employment of the practically trained nurse to meet the financial demands of the situation and the lack of personnel in the way of trained and registered nurses. It would be wrong for me with my interest in nurses and their future not to suggest to them that they take heed lest they educate and legislate themselves out of the important place they have held in medicine and in the community. It is really no exaggeration to say that, with many of the personal attentions to patients delegated to ward maids, the real art of nursing can be lost to the nursing profession."]

The above section in brackets, "The Nursing Situation," is reprinted from my Presidential Address, "Current Problems of American Medicine," before the American Medical Association at the Ninety-Second Annual Session, Cleveland, June 3, 1941.

While nearly everyone agrees with these sentiments expressed on June 3, 1941, and while everyone agrees that the care of patients is greatly handicapped by the shortage of nurses, there does not seem to be any immediate prospect of the situation being bettered.

Nurses are necessary for the practice of medicine and something should be done to improve the situation so that more nurses will be available. A shortage of nurses is resulting in beds remaining unoccupied because of lack of nurses to man them, something that is, to say the least, regrettable in times such as these when so many people with cancer and other urgent states have to wait literally weeks before they can get to hospitals and be cared for.

The easiest thing to do in a situation of this sort is to say what should happen, but to propose how to do it, is certain to result in conflict and disagreement. Nevertheless, when a situation is as pressing as is this one, it is the duty of everyone who is involved in it and who has ideas, to express them. There will be disagreement, there will be controversy, there may even be hostility, but we will make progress in a situation that is now static only by frank statements, and for this reason I wish to set down the views which I personally hold regarding present-day nurse education.

I do not believe that nurses need the amount of medical instruction that they now receive under the present nurse teaching curriculum.

I believe that many nurses not only will never use some of it, but do not comprehend some of it.

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* Reprinted from *The Lahey Clinic Bulletin*, April 1947.

I believe that too much of the nurses' time is spent away from the bedside and that much of the doctor's time in teaching them is in some measure wasted.

I believe that two years of high school education is an adequate amount of education for a service nurse to have in order to comprehend the basic principles of service nursing and I believe by this plan more nurses, so badly needed, will be obtained.

I believe that four years of high school is an adequate preliminary education for any nurse.

I believe that there should be two types of nurse education, one for the service nurse and one for the nurse educator.

I believe that the motif of nursing which once was so strongly stressed, personal service, is being lost and should be regained.

I believe that opportunities should be opened for nurses trained for service nursing to continue on to further advanced nursing education if their interests and aptitude indicate justification, irrespective of their degree of preliminary education. A lack of fundamental education can be and has been compensated for in medicine by application and aptitude and can be in nursing.

I believe that any hospital which does not have an adequate number of nurses or an adqate number immediately in prospect is failing to meet its obligations to a bed situation now acute and not improving if it is not attempting to increase its nursing personnel by organizing a service nursing program or something comparable with it.

I believe a program should be established as soon as possible jointly by the American Medical Association, American Hospital Association, American Nursing Association, The American Association of Medical Colleges, and the Catholic Hospital Association on what is the proper requirement for the training of a service nurse, and that until this is done no progress will be made.

THE NURSES STATE THEIR CASE

Ethel J. Odegard, R.N.

Executive Secretary, Nurses' Examining Board of the District of Columbia

Editor's Note: The following article was prepared at the request of the Editor. No group has a greater stake in what happens to the nurses than the nurses themselves. For that reason the views here expressed are of considerable significance.

Much has been said in recent months regarding the education and training of nurses. Indeed, considerable criticism has been directed toward those whose duty and function it is to set up and maintain standards in nursing education. These speakers and writers have, with good intentions, no doubt, presented their ideas about the selection of students, the length of the course, and the content of the curriculum. In one way or another they have said that the nurse did not need the kind of education she is receiving today and that it might be well for other interested groups to take the matter in hand.

What precedence exists in American professional education for this kind of thinking? Is it possible that right and proper educational standards for a vital profession should be seriously questioned? Or that persons other than those in the nursing profession should set the standards? Who sets the standards for the members of the teaching profession if not they themselves? Or the medical profession? Or the engineering societies, or the profession of the law? Nursing is an allied profession of medicine, it is true. Sometimes it is said to be the handmaiden of medicine, and is proud to be so considered. But nursing sets its own standards.

Certain fundamental principles of professional education exist in all fields. Foremost among these is that standards should be set up by those best fitted to judge by virtue of their experience and education in the particular field. Another is that members of a profession have the right to determine their own curriculum and to fix their own educational boundaries. Finally, the standards set by any profession must provide for growth and satisfaction of the individual as well as insure professional competency. In the nursing profession standards are formulated by nurses who are qualified to be administrators and teachers in accredited schools of nursing. They welcome assistance from their colleagues in the colleges and universities. It is the function of the Nurses' Examining Board to see to it that, after standards have been decided upon for the good of all, they are put into practice and maintained.

What possible inducement can there be to prospective candidates to enter any professional field if they cannot be assured of high standards? Have our critics thought of the many opportunities open to women today besides nursing? Do they know that high school vocational counselors when guiding young women into nursing stress the importance of selecting schools of nursing which maintain high standards?

The national picture must also be kept in mind when setting up standards. Schools of nursing do not conduct their educational programs in complete isolation. Although separate and independent institutions, they are a part of a nationwide educational system. Because of this their graduates should be eligible to practice their profession in any one of the 48 states. Fortunately, standards in the District of Columbia bear a favorable relation to those which exist elsewhere. It is just possible that the reason there are any students at all in the hospital schools of nursing here is due to the fact that graduates who have received their training here are able to hold their own in any part of the country. Surely the physical environment of the hospitals cannot claim credit for attracting students. There must be something else. Indeed, the hospital situation in the District of Columbia suggests the description of the old and venerable college buildings by Stephen Leacock in "Oxford as I See It." The fame of Oxford rests with its distinguished and renowned teachers. Whatever fame the schools of nursing in the District of Columbia may have must be attributed to the type and kind of education afforded its students.

Professional standards should not be influenced by student enrollment. Whether there are many or few in a given field should have no bearing on the standards agreed upon. It is said that many now teaching are not qualified. This is greatly deplored. In no instance, however, has the suggestion been made that the quality or the preparation of teachers should be decreased in this emergency. No one suggests, because a community has need for more doctors, dentists, pharmacists, or lawyers that consideration should be given, and indeed, coercion attempted, to admitting candidates with less aptitude, or to reducing the hours in the curriculum, or the length of the course. It is our opinion that the public believes that its security in obtaining professional service of a high order in these respective fields rests both on a superior person and a high standard of preparation. No one suggests letting down the bars.

The Nurses' Examining Board of the District of Columbia is authorized by law to maintain standards for the accredited schools of nursing, and to register graduate professional nurses who meet the requirements. This does not imply that hospitals are re-

EMERGENCY MATERNITY AND INFANT CARE PROGRAM

The D. C. Health Department has been notified by the U. S. Children's Bureau that Congress has provided for the continuation of the Emergency Maternity and Infant Care Program and for its gradual termination. All maternity and infant care for wives or infants of servicemen of the four lowest pay grades for whom care has been authorized prior to June 30, 1947 will be completed.

Maternity care will be authorized after June 30, 1947, if the mother was eligible under the program as of June 30, 1947, even though she may apply for care after that date.

If the mother or infant was eligible for care or received care as of June 30, 1947, infant care will be authorized after June 30, 1947. For example, if the wife of a serviceman in the eligible pay grades became pregnant before June 30, 1947, she would be eligible for the services of a physician and hospital care until six weeks after the birth of the baby. Her infant would be eligible for care until one year of age.

Care for wives and infants of veterans who were in the eligible pay grades will be authorized provided that the mother became pregnant before the father was discharged.

Applications for maternity and infant care in the District of Columbia should be made through the Bureau of Maternal and Child Welfare of the Health Department, 300 Indiana Avenue, N.W., Room 6038, National 6000, Extension 2150.

quired to conduct schools of nursing. But if it is their desire to do so, then the standards as set up by the Board must be accepted and maintained. Surely, the Board cannot with integrity, which operates in this field as in any other, maintain a sort of see-saw with respect to either admission or curriculum standards. Neither the public nor the nurse will be protected in this manner.

The nursing profession will continue in its endeavors to select those applicants who are best fitted for the profession, and to develop its curriculum in the manner it thinks best. Physicians, patients, and hospital administrators will find that this plan will give the greatest satisfaction in the days and months ahead.

AMA CONCLUDES HISTORIC CONVENTION

The Centennial Convention of the American Medical Association, which was held in Atlantic City, June 9–13, was attended by 15,667 Fellows from the United States and foreign countries and a like number of guests. Some 200 physicians from Washington were present for all or part of the week. Official representatives of the District Medical Society were its delegates, Drs. C. B. Conklin and Herbert P. Ramsey. Among the officers of the Society who attended were Dr. William P. Herbst, President; Dr. Raymond T. Holden, President-elect; Theodore Wiprud, Secretary; and J. Richard Connelly, Assistant Secretary.

At the opening session in Convention Hall, June 10, Dr. Edward L. Bortz, Philadelphia, was installed as the new President of the AMA. Presiding was the retiring President, Dr. Harrison H. Shoulders, of Nashville, Tennessee. Following his Presidential Address, Dr. Bortz awarded the 1947 Distinguished Service Medal for scientific advancement in the field of medicine today to Dr. Henry A. Christian of Brookline, Massachusetts. Dr. Christian has been noted through the years for his work in pathology. Since 1939 he has been Professor Emeritus of Medicine at Harvard University Medical School.

Dr. R. L. Sensenich, Chairman of the AMA's Board of Trustees, was named President-elect. He will take office in 1948.

Dr. Herbst took a very active role in the Convention. He read a paper on "The Problem of the Posteriorly Located Renal Pelvis Associated with Ptosis" before the Section on Urology, June 11. He was a member of the Committee on Awards for the Scientific Exhibit. At the request of the Medical Society's Executive Board, he represented the Society at a meeting of the Associated State Postgraduate Committee, June 11.

Mr. Wiprud, as Chairman of the Medical Society Executives Conference, presided at its first annual meeting, which was held at Chalfonte-Haddon Hall, June 11. The following program was presented: "The Standardization of Membership Records of Medical Societies," Frank Cargill, Manager of the Directory Department of the AMA; "A Program Director's View of Medical and Health Radio Programs," Dwight Herrick, Manager, Public Service Department of the National Broadcasting Company; "What a City Editor Looks for in a News Release," William Hill, City Editor, *Washington Evening Star;* "The Technic of Executive Management," Dr. Martin Lasersohn, Vice President, Winthrop Chemical Company. The meeting was followed by a reception and dinner. Guest speaker at the dinner was Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital, who gave an address on "What Is Wrong with Executives?"

On June 8, just preceding the Convention, the National Conference of County Medical Society Officers held its first annual "Grass Roots Conference." As a participant in a question-and-answer panel, Mr. Wiprud discussed public relations procedures.

Medical Society members contributed three papers to the program of the Section on Pediatrics. They were: "Centennial Address: Progress in Pediatrics," Dr. Edgar P. Copeland; "Psychotherapy and the Pediatrician," Dr. Dorothy Donley-Dowd; and "The Role of Cow's Milk in Gastrointestinal Allergy of Children," Drs. Preston A. McLendon and Dorothy S. Jaeger-Lee. Dr. Lloyd G. Lewis addressed the Section on Urology on "Radical Orchiectomy in the Treatment of Testis Tumors," and Dr. Joseph T. Roberts read a paper on "Ischemia of Peripheral Nerves: Experimental and Clinical

Studies on the Role of the Vasa Nervorum" before the Section on Nervous and Mental Diseases.

Drs. Harry Ford Anderson, Brian B. Blades, Ethel C. Dunham, Lloyd H. Mousel, Winfred Overholser, Mark P. Schultz and Joseph B. Sheffery were among those who led in discussion of papers.

Ten members of the Society participated in the Scientific Exhibit. For his exhibit on "Hyperhidrosis—Surgical Management," Dr. J. Ross Veal received Honorable Mention from the Committee on Awards.

Dr. Overholser coöperated with Dr. Frank H. Krusen, Rochester, Minnesota, and Dr. Howard A. Rusk, New York, on a Special Exhibit on Physical Medicine. Other exhibits originating locally were: "Protein Metabolism in Surgery; Use of Oral and Parenteral Protein Hydrolysate," Dr. Jacob J. Weinstein; "A Simple Technic of Low Magnification Gonioscopy," Dr. Ernest Sheppard; and "Oil Soluble Metals in the Treatment of Leukemia," Dr. Charles F. Geschickter. Dr. Roy Hertz of the National Cancer Institute presented an exhibit on "Hormonal Control of Tissue Growth," and Dr. G. Foard McGinnes, of the American National Red Cross, "Blood Donor Service."

In connection with a Special Exhibit on Fractures, Drs. Frank M. Hand and Leonard T. Peterson, with a number of other orthopedic surgeons, assisted the committee with demonstrations.

With the coöperation of the Section on Internal Medicine two question and answer conferences were conducted. Dr. Wallace M. Yater and Dr. Veal were among the participants. On June 10 Dr. Yater led discussion on "The Peripheral Arterial Diseases," and on June 11, Dr. Veal presented the topic, "Surgical Treatment for Vascular Diseases," for discussion.

Medical aspects of atomic warfare were presented by the U. S. Navy and the U. S. Army. The Navy's exhibit was entitled "Operation Crossroads," while the Army displayed transparencies showing clinical and pathologic aspects of atomic warfare.

Of particular interest to physician-philatelists was the special three-cent stamp commemorating the AMA Centennial, issued on the first day of the Convention, June 9. "In so honoring the American doctor," Postmaster General Hannegan said, "we are paying tribute to the men and women of medicine who devote their lives to the cause of humanity. Alleviation of pain and suffering and the betterment of mankind are their creed. The contribution which they have made to our national life is one of which all America can be proud and grateful." The original painting of "The Doctor," Sir Andrew Clark, whose portrait appears on the stamp, was loaned to the AMA by the Tate Gallery of London.

New and unusual displays were found in the Technical Exhibit. Smith, Kline and French Laboratories produced an authentic 1793 apothecary shop complete in every detail. In coöperation with the American Physicians' Art Association and Literary Guild, Mead Johnson and Company sponsored the annual art exhibit. White Laboratories, Inc. donated a new Cadillac club coupe which was won by one of the registrants at their booth.

Chicago was selected as the meeting place for the 1948 Convention.

REPORT ON ULTRAVIOLET BLOOD IRRADIATION

The Amercan Blood Irradiation Society held its annual meeting this year at Atlantic City, June 8, the day before the convention of the American Medical Association. It plans similar arrangements next year at the Chicago meeting of the AMA.

Among the papers presented before members of the Society were "Physics of Blood Irradiation" by Dr. D. P. Ward, Pemberville, Ohio, and "Ultraviolet Blood Irradiation Treatment in 650 Cases of Pelvic Cellulitis" by Dr. R. J. Olney, of the Olney Clinic, Lincoln, Nebraska. This latter paper has been accepted for publication in the October number of *American Journal of Surgery*.

Dr. George P. Miley, of New York City, presented a paper on "Ultraviolet Blood Irradiation Therapy in Acute Virus and Virus-like Infections" before the twelfth annual convention of the National Gastroenterological Association, which met in Atlantic City along with the AMA. Its publication will be in the journal of this organization.

The American Blood Irradiation Society was organized to encourage the study, maintain and improve the standards, and advance the knowledge of blood irradiation. The Knott-Hemo-irradiator, endorsed by this group, is the only development so far which enables the uniform irradiation of such opaque substances as blood, and holds the exposure time safely within the narrow range which has the desired therapeutic values. All the published clinical reports by members of this group are based on the use of this device in accordance with the recognized Knott Technic of blood irradiation.

The use of the Knott Hemo-irradiator for ultraviolet blood irradiation is strictly limited to medical graduates eligible for membership in the American Medical Association, and within that group it is limited to those physicians who are willing, before obtaining the equipment, to thoroughly learn the Knott Technic from a physician who is adequately grounded in this technic.

Centers for ultraviolet blood irradiation by the Knott Technic have already been established in the following cities: New York, Brooklyn, Philadelphia, Washington, Pittsburgh, Cleveland, Detroit, Dayton, Abilene, Lincoln, North Platte, Denver, Los Angeles, Seattle, Grants Pass (Oregon), and Pasco, Walla Walla and Bellingham (Washington).

G. J. P. Barger, M.D.
Secretary-Treasurer, American Blood Irradiation Society

CASH SICKNESS BENEFITS FOR RAILROAD WORKERS

A cash sickness benefit system for railroad workers began operating throughout the Nation on July 1. These benefits were added under the 1946 amendments to the Railroad Unemployment Insurance Act and provide partial compensation for wage loss due to disability on the same basis as that due to unemployment. The system will be administered by the Railroad Retirement Board, which administers the Railroad Unemployment Insurance Act.

All disabilities which prevent railroad employees from working, regardless of how or where they occur, are covered under the program. In the first year of operations, about 300,000 of the 2,075,000 railroad workers qualified are expected to receive benefits, and the total amount of benefits is expected to reach $36,000,000.

A physician's statement of sickness will be required before claims can be paid. It is believed that the program will require about 650,000 medical examinations a year. Employees are free to choose their own doctors, and any physician to whom an employee goes for examination or treatment may supply the information required as initial proof of an employee's claim.

The forms on which medical information will be requested from a physician are the "Statement of Sickness" and the "Supplemental Doctor's Statement." The first mentioned form is intended primarily to obtain information at the beginning of each illness, and the second is intended to obtain additional information only when such information is needed later on in the same illness. The statements are designed to furnish, as simply and as conveniently as possible for the physician, the minimum information required for Board purposes.

The "Statement of Sickness" on which the medical evidence is to be furnished must be mailed to the appropriate office of the Railroad Retirement Board within seven days after the first day claimed as a day of sickness, or the employee may lose part of his benefits. Claims for succeeding fourteen-day periods may be allowed for a predetermined period as indicated by the medical evidence on the doctor's initial statement, but in continuing illnesses supplemental information about the patient's illness may also be requested from the physician.

Claims will be filed and adjudicated in the regional offices of the Railroad Retirement Board. These offices are located in Atlanta, New York, Cleveland, Chicago, Dallas, Kansas City, Minneapolis, Denver and San Francisco and serve the adjoining territories. Each will have a physician who will act as a medical consultant. Mr. H. W. Murphy is the Manager of the U. S. Railroad Retirement Board for the District of Columbia. His address is 1624 H Street, N.W. Physicians wishing additional information regarding this program should call Mr Murphy at Republic 1780.

Washington Physicians of Yesterday

ADA REBECCA THOMAS, M.D.

A prominent representative of the women physicians of Washington, and an outstanding practitioner in her time, was Dr. Ada Rebecca Thomas, who was born August 6, 1868, in Trenton, New Jersey. She received the degree of M.D. from the Woman's Medical College of Pennsylvania in 1893, and then, 1893–94, served as intern in the Woman's Hospital in Philadelphia, and as resident for eighteen months in the Philadelphia Hospital. In December, 1894, she removed to Washington, D. C., where she lived and engaged in the practice of medicine for the remainder of her life. She died of meningitis, May 1, 1925, after a brief illness.

Of a forceful and pleasing personality, Dr. Thomas was an able and active practitioner of general medicine, and she won the confidence, appreciation, and esteem of her clientele, her professional confrères, and the community. She was active in committee and official service in the local medical organizations, having been vice president and a member of important committees of the District Medical Society, and president and charter member of the Women's Medical Society. She had various hospital connections, as with the Women's Clinic, Emergency Hospital, member of the staff and advisory council of Sibley Hospital, chief of staff of the Florence Crittenton Home, and instructor in nurses' training schools. She had a wide range of interests and activities apart from medicine, especially in religious and philanthropic fields. She was vice president of the College Women's Club, and a member of the American Association of University Women and of the Women's City Club. She was a member of the Official Board of Foundry Methodist Episcopal Church, and a vigorous promoter and director of the Young Women's Christian Association.

John B. Nichols, M.D.

News and Personals

The attention of physician-veterans of World War II is called to the **"Analysis of Replies to Postwar Questionnaire"** which is now ready for distribution by the American Medical Association. An "Analysis of Questionnaire on Medical Care of Civilians during World War II" was published in the *Journal of the AMA* for May 24. Dr. Frank G. Dickinson, Director of the Bureau of Medical Economic Research, says it is rather unlikely that the analysis will be published in the *Journal*, but that he will honor any written request from a discharged medical officer for one copy of the "Analysis of the Postwar Questionnaire." He may be addressed at 535 North Dearborn Street, Chicago 10, Illinois.

All officers and former officers of the **Medical and Dental Corps of the Army** will have until the end of July to apply for **Regular Army Commissions.** Extension of time for applications for commissions from physicians and dentists was granted as a result of shortages in these classifications in the first three increments of the Regular Army Officer Integration Program. Any medical or dental officer who is now on active duty or who saw service with the Army during World War II hostilities will be eligible to submit his application to The Adjutant General.

The recall of 20 Medical Corps Reserve Officers annually for a period of 90 days, for the purpose of attending a course of instruction and training in **Aviation Medicine,** was recently announced by the War Department.

The course of instruction, which is being presented under the technical supervision of The Air Surgeon at the AAF School of Aviation Medicine, Randolph Field, Texas, covers a study of the fundamentals of aviation medicine with special emphasis placed on the principles and practice of medicine as they apply to aviation and the efficient performance of the "64" Physical Examination for Flying. Each graduate will receive a certificate designating him an Aviation Medical Examiner.

Eligibility for the course requires the applicant to be under 40 years of age, meet minimum physical requirements for flying, and have an efficiency index of 4.0 or above, and not currently designated a Flight Surgeon or Aviation Medical Examiner. The physical examination may be obtained at most Army Air Force stations, or an examination by any Flight Surgeon or Aviation Medical Examiner is acceptable.

The first class will begin October 6 and extend through December 12, 1947. Government quarters will be available at Randolph Field for students enrolled in the course. Facilities will not permit quarters for dependents.

Applications for this training should be made by letter, accompanied by a copy of the WD AGO 64, "Physical Examination for Flying," to the Office of the Surgeon General, Attention: Military Personnel Division, by not later than August 15, 1947.

The books of **Group Hospitalization, Inc.** will be open again to new members, September 1. Applications should be filed with the Society's Secretary on or before August 20. Application blanks may be secured by calling District 3111.

The Indiana State Board of Medical Registration and Examination has requested the announcement in the ANNALS of a new law requiring annual registration of physicians, effective July 1. The notice states that "every person who now holds, or may hereafter hold, a valid and unrevoked certificate for a license to practice the Healing Art. . .shall be required to register with the said Board, during the month of July and not later than the last day of August, immediately following the effective date of this Act, which registration shall be for the period ending June 30, 1948, and shall, annually thereafter, on or before August 31 of each year, be required to register with said Board." For residents of Indiana the annual registration fee is $5.00; for non-residents, $10.00. Failure to comply with the provisions of this Act "shall operate automatically to cancel his/her certificate, and license issued thereunder shall be considered as practicing without license. A certificate cancelled for failure to register may be reinstated by said Board upon submission of the applicant's last registration certificate together with current and delinquent fees, and a penalty in the sum of $10.00."

Washington physicians who desire to retain their Indiana licenses may secure an application for registration by addressing the Board at 416 K. of P. Building, Indianapolis 4, Indiana.

The George Washington University Medical Society held its annual business meeting and election of officers, May 24. Dr. J. Burton Glenn gave the President's Address, following which the guest speaker, Dr. Hans F. Smetana, addressed the Society on "The Pathology of Lower Nephron Nephrosis." Dr. Smetana is head of the Department of Pathology of the Army Institute of Pathology.

New officers elected for 1947–48 were as follows:

Dr. James I. Boyd, *President-elect;* Dr. Herbert S. Gates, *First Vice President;* Dr. Carolyn Pincock, *Second Vice President;* Dr. Oscar B. Hunter, *Secretary-Treasurer.*

Dr. Clyde P. Reeves succeeds Dr. Glenn as President of the Society. Dr. Glenn was named to the Executive Council for a five-year term.

Impressive services were held at the Washington Cathedral, June 1, when the **Physician's Window** was dedicated by Dr. Angus Dun, Bishop of the Washington Episcopal Diocese. Dr. Frank J. Sladen, Physician-in-Chief at the Henry Ford Hospital, Detroit, gave the dedicatory address. The Window was given in memory of Dr. Elmer Burkitt Freeman by his widow, Rosa C. Freeman.

Dr. Freeman was Physician-in-Chief of Maryland General Hospital in Baltimore at the time of his death in December 1942. A native of Matoon, Illinois, he graduated in medicine from the old Baltimore Medical College. He was a member of many scientific organizations, including the American Medical Association and the American College of Physicians.

The Physician's Window, in the east wall of the North Transept of the Cathedral, consists of three lancets and tracery. In the center lancet stands Christ, the Great Physician; to the left, Louis Pasteur; and to the right, Sir Wilfred Grenfell, famous Labrador physician. In the tracery can be seen the Caduceus, the Red Cross, the Tuberculosis Cross, the Pool of Bethesda, the brazen serpent, and, at the apex of the Window, a dove symbolizing the Holy Spirit. The Window was designed and executed by Wilbur Herbert Burnham. It is the first of three windows to be dedicated to the professions; the other two will symbolize education and law.

The D. C. Pharmaceutical Association closed its two-day annual convention with a banquet at the Mayflower Hotel, June 19. Presiding during the program which followed the dinner was Mr. W. Paul Briggs, Chief of the Division of Pharmacy, Veterans Administration. Life membership in the American Pharmaceutical Association was conferred upon Mr. A. C. Taylor by the local Association. Mr. Taylor is Honorary President of the A.P.A. and President Emeritus of the District Association. Among the dinner guests were President William P. Herbst of the Medical Society and Mr. and Mrs. Theodore Wiprud.

Mr. Paul Reznek was elected new President of the Association. Mr. Harold C. Kinner and Mr. Roger Lusby were reëlected Secretary and Treasurer, respectively.

At the meeting of the **Section on Neurology and Psychiatry,** April 30, the following officers were elected for the coming year:

Dr. Isadore Rodis, *Chairman;* Dr. O. Hugh Fulcher, *Vice Chairman;* Dr. Harold Stevens, *Secretary-Treasurer.*

The annual spring banquet of the **George Martin Kober Medical Society** was held at the Kenwood Country Club on May 19 for members and invited guests. The guest speaker at the dinner was Congressman Frank Fellows, of Maine, who addressed the Society on subjects pertinent to medicine. Dr. Don S. Knowlton, President of the Society, presided.

The Association of Undergraduate and Practical Nurses of the District of Columbia announces the opening of a Nurses Registry at 4839 Wisconsin Avenue, N.W. The telephone number is Woodley 3266.

The Louis Mackall Medical Society held its annual outing and dinner, May 13, at the Congressional Country Club.

The following officers were elected for the coming year:

Dr. Walter Atkinson, *President;* Dr. Leo B. Gaffney, *Vice President;* Dr. J. Lawn Thompson, *Secretary-Treasurer.*

The District Dental Society elected new officers at its final meeting of the season, June 10. Dr. M. M. Alexander succeeds Dr. Joseph A. Madden as President of the Society. Dr. Edward D. Leifer is the new President-elect; Dr. William Curtis, Vice President; and Dr. Karl H. Wood, Secretary-Treasurer.

The Society for Experimental Biology and Medicine, District of Columbia Section, held its annual dinner meeting at the Y.W.C.A., June 5. W. H. Sebrell, Jr., Chief of the Division of Physicology of the National Institute of Health, spoke on "Nutritional Status of German Civilians."

Samuel H. Kauffmann, Business Manager of the *Evening Star*, succeeds George A. Garrett as President of the Board of Directors of **Emergency Hospital.** Mr. Garrett was forced to vacate the post when he was named United States Minister to Ireland. Mr. Kauffman has been a member of the Board since 1938.

At the annual meeting of the Board of Trustees of **Group Hospitalization, Inc.,** May 19, all officers were reëlected. They are as follows: Joseph H. Himes, President; Alfred G. Neal, First Vice President; Charles D. Drayton, Second Vice President; Dr. Walter A. Bloedorn, Secretary; and Sidney F. Taliaferro, Treasurer.

Dr. Oscar B. Hunter, Sr., Bruce Baird and Mark Lansburgh were elected trustees.

Dr. Winfred Overholser took office as the new President of the **American Psychiatric Association** at its 103rd annual meeting in New York, May 19–23. During the sessions, several papers were presented by members of the District Medical Society: "The Myth of the Psychopathic Personality," Dr. Benjamin Karpman; "New Trends in Hospital Design," Drs. Paul Haun and Z. M. Lebensohn; "Modern Psychiatry in General Practice," Dr. Leonard M. Dub; "Outpatient Treatment of Chronic Alcoholics," Dr. Leopold E. Wexberg; and "Penicillin Therapy in General Paresis," Dr. George D. Weickhardt. Dr. Walter Freeman discussed a report on lobotomy studies at the Boston Psychopathic Hospital and also participated as a discussant at one of the round table dinner meetings.

Local physicians elected to Fellowship in the Association were Drs. Norman Q. Brill and Alvin B. C. Knudson; to membership, Drs. Sidney Berman, Jerome D. Frank, Marshall deG. Ruffin and Harvey H. Ammerman.

The new President-elect of the Association is Dr. Karl A. Menninger, of the Menninger Clinic, Topeka, Kansas. Drs. Robert H. Felix and S. W. Hamilton of the Mental Hygiene Division of the U. S. Public Health Service were elected Councilors.

A new publication, *The Bulletin*, the official publication of the Georgetown University Medical Center, has just been received in the Society's office. Designated as a "teaching publication for the dissemination of scientific information of Medicine, Dentistry and Nursing interests," the journal will be published bi-monthly on the 10th of the month. The material will be prepared by members of the Staff.

Dr. Stephen W. Nealon, Jr., Associate Clinical Professor of Medicine at Georgetown University School of Medicine, is Editor of the new *Bulletin.* The first number (June–July) was dedicated to Dr. Joseph J. Mundell, who retired July 1 as Professor of Obstetrics and Director of the Department of Obstetrics of the University.

Dr. Ross T. McIntire has succeeded **Dr. Herbert P. Ramsey** as Chairman of the Washington Metropolitan Health Council. The nomination was made at a luncheon meeting of the Coördinating Board at the Roger Smith Hotel, June 5, and later approved by the Council of Social Agencies. Dr. Ramsey, who has served as Chairman of the Council since its inception in the fall of 1944, will continue as a member of the Executive Committee.

New members elected to the Executive Committee by the Board were Colonel Waldron Leonard, Director, Division of Services to Veterans, Veterans Administration; Mrs. Emma Appleman, Chairman of Public Health, Federated Women's Clubs of Maryland; Mr. D. C. Book, Secretary, Chamber of Commerce of Alexandria; and Dr. Vane M. Hoge, Medical Director and Chief of Hospital Facilities Division, U. S. Public Health Service.

Two more Washington physicians have returned to active practice: **Dr. Robert G. Taylor** opened his office, July 1, at 1150 Connecticut Avenue, and **Dr. G. Louis Weller, Jr.,** is practicing at 1201 19th Street, N.W. Both physicians have served in the Army Medical Corps since 1944 and were discharged with the rank of Captain.

Three Society members are reported as having transferred to the Regular Navy. They are as follows: **Comdr. John W. Thomas,** now at the Naval Air Station, Alameda, Calif.; **Comdr. James H. Gillen,** Naval Hospital, Quantico, Va.; and **Lt. George W. Russell,** NAS Whiting Field, Pensacola, Fla.

Rear Admiral Clifford A. Swanson, the new Surgeon General of the Navy and Chief of the Bureau of Medicine and Surgery, was elected to Honorary membership in the Medical Society at the Annual Business Meeting, May 7, upon the recommendation of the Executive Board. In so doing the Society honored Admiral Swanson not only for elevation to his present high office but for his outstanding work in ophthalmology and otolaryngology.

Dr. Leonard A. Scheele became Chief of the National Cancer Institute, July 1, succeeding **Dr. R. R. Spencer,** who resigned to devote full time to cancer education and research. Dr. Spencer will also direct the Institute's program of training young physicians in the diagnosis and treatment of cancer. He is well known for his work in developing a vaccine for tick fever.

Dr. Scheele, who has served on the staff of the U. S. Public Health Service since 1933, was formerly Assistant Chief of the Institute. During the War he was in charge of the Preventive Medicine Section for the Allied forces in Northwest Europe. He received the Legion of Merit and other decorations.

At the commencement exercises of **George Washington University School of Medicine,** held at Constitution Hall, May 28, Dr. Roger M. Choisser, Professor of Pathology, conferred degrees in medicine upon his son, Robert V., his daughter, Mrs. Marion Choisser Mills, and his son-in-law, Stephen Roy Mills, Jr.

Achievement awards were presented to six alumni of the University by Dr. Alexander Wetmore, President of the University's General Alumni Association. Among those so honored was **Dr. Sterling V. Mead,** President of the American Dental Association, who is an Associate member of the District Medical Society.

Dr. Wyrth Post Baker has been appointed a member and Secretary of the Board of Medical Examiners for the District of Columbia, replacing **Dr. Gregg C. Birdsall,** who resigned.

Dr. J. Ross Veal was elected to serve on the Board of Directors of the American Heart Association at its recent meeting in Atlantic City.

Dr. Joseph T. Roberts read a paper entitled "The Effect of Occlusive Arterial Diseases of the Extremities on the Blood Supply of Nerves" before the American Heart Association, June 6, in Atlantic City. He also addressed the American Diabetes Association, June 8, on "Globin Insulin."

Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, led a symposium on health at the 50th annual convention of the National Congress of Parents and Teachers in Chicago, June 3.

Dr. Albert S. Winer is conducting an Ear Clinic at Suburban Hospital under the auspices of the Montgomery County Health Department. The primary purpose of this clinic is to prevent deafness in children.

Major General Shelly U. Marietta, U.S.A. (retired) was elected President of the American College of Chest Physicians at its meeting in Atlantic City, June 11.

Dr. Walter Stokes addressed the Columbus, Ohio, Planned Parenthood Association, May 15, on "Marriage Counseling as a Community Service." He also conducted a seminar for Columbus doctors, ministers, educators and social workers on the problems of marriage.

CORRESPONDENCE

Washington, D. C., June 20, 1947
Mr. Theodore Wiprud
Secretary, Medical Society, D. C.
1718 M Street, N. W.
Washington, D. C.

Dear Mr. Wiprud:

In connection with the proposed cancer survey in the District of Columbia some question was raised with regard to the liability of hospitals or physicians in furnishing the names of patients afflicted with cancer under their care. In order to resolve the doubt as to the question of liability of so participating in the cancer survey, the question was submitted to the Corporation Counsel of the District of Columbia. The following is quoted from the Opinion of the Corporation Counsel submitted under date of June 11, 1947:

> "It is accordingly the opinion of this office that disclosures of the desired information to public authorities in cancer cases for confidential use in combating that disease, which is said to be a disease which causes a very high death rate, is not in violation of any District of Columbia law and would not subject a physician or hospital disclosing such information in confidence to public officers to any liability As a precautionary measure it might be well for each physician and hospital to state on the return that the information given thereon is confidential and that the names of patients should not be divulged."

Very sincerely,
George C. Ruhland, M.D.
Health Officer, D.C.

BOOK REVIEW

Gynecology with a Section on Female Urology, 2nd ed. Lawrence R. Wharton, Ph.B., M.D., Assistant Professor of Gynecology, The Johns Hopkins Medical School; Assistant Attending Gynecologist, The Johns Hopkins Hospital; Consultant in Gynecology, The Union Memorial Hospital, Hospital for the Women of Maryland, Sinai Hospital and Church Home and Infirmary. Price, $10.00. Pp. 1027, with 479 illustrations. Philadelphia: Saunders, 1947.

This book, written in a reasonably concise yet thorough manner, can well be utilized by student, general practitioner, and gynecologist.

The chapters on the anatomy of the pelvis, embryology of the genitourinary system, and sterility are scholarly; those on postoperative care, normal hygiene, and the art of diagnosis are welcome and well-done contributions to the gynecologic textbook. The historical data given are refreshing, and in general the author has distinguished between personal opinion and established fact.

The material on urology is perhaps an isolated instance of excessive thoroughness; it is hard for the reviewer to see the need for the extensive material on nephrectomy, pyelotomy, and surgical therapy of renal and ureteral lesions, although the diagnostic procedures with air and water cystoscopy and general therapy are well covered and within the field of the gynecologist. A section on urology in a gynecologic textbook is unique and timely.

The author has seemingly placed equal stress on rare and common lesions so far as allotment of space, and this factor might permit novices in the field misconceptions as to the relative importance of some subjects; for example, 8 pages and 8 half-tones are given to the Watkins-Schauta-Wertheim operation, 4 pages and 7 half-tones to the Donald-Fothergill procedure, and only 2 lines to the LeFort operation. No mention is made of cyclic ovarian substitution therapy for functional uterine bleeding, yet almost a page is devoted to the androgen therapy of this condition.

The treatment in general as outlined is standard, but specific instructions are not given as to its application, so that the book cannot be used as a treatment manual.

The illustrations are excellent, the index adequate, and the scope very broad. The bibliography is fairly comprehensive, but all the references in the text are not included.

L. V. D.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

Surgical Pathology, 6th ed. William Boyd, M.D., Dipl. Psych., M.R.C.P. Ed., F.R.C.P. Lond., LL.D. Sask., M.D. Oslo, F.R.S.C., Professor of Pathology, The University of Toronto, Canada. Price, $10.00. Pp. 858, with 530 illustrations, including 22 color figures. Philadelphia: Saunders, 1947.

A Textbook of Medicine, 7th ed., edited by Russell L. Cecil, A.B., M.D., Sc.D., Professor of Clinical Medicine, Cornell University Medical College; Consulting Physician, New York and Veterans' Hospitals; Visiting Physician, Bellevue Hospital, New York City; with the assistance of Walsh McDermott, M.D., Associate Professor of Medicine, Cornell University Medical College, and Harold G. Wolff, M.D., Associate Editor for Diseases of the Nervous System; Associate Professor of Neurology, Cornell University Medical

College. Price, $10.00. Pp. 1730, with 244 illustrations. Philadelphia: Saunders, 1947.

Diseases of Metabolism—Detailed Methods of Diagnosis and Treatment—A Text for the Practitioner, 2nd ed., edited by Garfield G. Duncan, M.D., Director of Medical Division, Pennsylvania Hospital; Clinical Professor of Medicine, Jefferson Medical College, Philadelphia. Price, $12.00. Pp. 1045, with 167 figures. Philadelphia: Saunders, 1947.

A History of the American Medical Association, 1847-1947. Morris Fishbein, M.D., with the Biographies of the Presidents of the Association by Walter L. Bierring, M.D., and with Histories of the Publications, Councils, Bureaus, and Other Official Bodies. Price, $10.00. Pp. 1226. Philadelphia: Saunders, 1947.

Diseases of the Chest: with Emphasis on X-Ray Diagnosis. Eli H. Rubin, M.D., F.A.C.P., F.C.C.P., Attending Physician, Division of Pulmonary Diseases, Montefiore Hospital and Country Sanatorium, New York; Visiting Physician in Tuberculosis and Physician-in-charge, Chest Clinic, Morrisania City Hospital, New York. Price, $12.00. Pp. 685, with 355 illustrations, including 24 plates in color. Philadelphia: Saunders, 1947.

Gynecology with a Section on Female Urology, 2nd ed. Lawrence R. Wharton, Ph.B., M.D., Assistant Professor of Gynecology, The Johns Hopkins Medical School; Assistant Attending Gynecologist, The Johns Hopkins Hospital; Consultant in Gynecology, The Union Memorial Hospital, Hospital for the Women of Maryland, Sinai Hospital and Church Home and Infirmary. Price, $10.00. Pp. 1027, with 479 illustrations. Philadelphia: Saunders, 1947.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgment is made:

"The United States Public Health Service Communicable Disease Center." Justin M. Andrews. Public Health Reports, August 16, 1946.

"Mertricone: A Chemical Sterilization Solution." Gaspar Angelo and Goldsmith H. Conant, Jr. Medical Times, October 1946.

"Precipitin Technique for Determining Mosquito Blood Meals." E. H. Arnold, S. W. Simmons and Dorothy G. Fawcett. Public Health Reports, August 23, 1946.

"Diverticula of the Digestive Tract." Wm. M. Ballinger. Southern Medical Journal, November 1946.

"Physical Therapy in a General Practice." G. J. P. Barger. Southern Medical Journal, September 1946.

"Separation of the Complement-Fixing Agent from Suspensions of Yolk Sac of Chick Embryo Infected with the Karp Strain of Tsutsugamushi Disease (Scrub Typhus)." Ida A. Bengtson. Public Health Reports, September 27, 1946.

"Still's Disease (Atrophic Arthritis, Atrophic Rheumatoid Arthritis or Infectious Rheumatoid Arthritis)." William Foster Burdick. Southern Medical Journal, August 1946.

"Food Dehydration Wastes." F. E. DeMartini, W. Allan Moore and G. E. Terhoeven. Public Health Reports, Supplement No. 191, 1946.

"The Trend of Tuberculosis Association Programs." Louis I. Dublin. American Journal of Public Health, October 1946.

"Skin-Sensitizing Properties of DDT for the Guinea Pig." John E. Dunn, Robert C. Dunn and Barbara S. Smith. Public Health Reports, November 8, 1946.

"Remarks on the Philosophy of Mental Disorder." Frieda Fromm-Reichmann. Psychiatry: Journal of the Biology and Pathology of Interpersonal Relations, November 1946.

"Sickness Absenteeism among Male and Female Industrial Workers during 1945, with a Note on the Respiratory Epidemic of 1945–46." W. M. Gafafer. Public Health Reports, November 8, 1946.

"Negro Mortality. II. The Birth Rate and Infant and Maternal Mortality. Mary Gover. Public Health Reports, October 25, 1946.

"Chemoprophylaxis of Experimental Influenza Infections in Eggs." R. H. Green, A. F. Rasmussen, Jr., and J. E. Smadel. Public Health Reports, September 27, 1946.

"Preparation of Mumps Vaccines and Immunization of Monkeys against Experimental Mumps Infection." Karl Habel. Public Health Reports, November 15, 1946.

"Winter Survival of *Aedes aegypti* (L.) in Houston, Texas." Stephen P. Hatchett. Public Health Reports, August 23, 1946.

"A New Pharyngoscope." A. R. Hollender. The Eye, Ear, Nose and Throat Monthly, July 1946.

"Rickettsialpox—A Newly Recognized Rickettsial Disease. I. Isolation of the Etiological Agent." Robert J. Huebner, Peggy Stamps and Charles Armstrong. Public Health Reports, November 8, 1946.

"The Removal of the Cercariae of *Schistosoma mansoni* from Water by Filtration through Diatomaceous Silica in a Small Model Filter." Myrna F. Jones and Frederick J. Brady. Public Health Reports, October 25, 1946.

"Abdominal Pregnancy with Placenta Attached to the Spleen." David H. Kushner and F. A. Dobrzynski. American Journal of Obstetrics and Gynecology, July 1946.

"An Evaluation of the Use of Multiple Versus Single Precordial Leads, in Conjunction with the Three Limb Leads, for Practical Clinical Electrocardiography." Benjamin Manchester and Clayton B. Ethridge. American Heart Journal, May 1946.

"The Velocity of Blood Flow in Normal Pregnant Women." Benjamin Manchester and Samuel D. Loube. American Heart Journal, August 1946.

"Statistics of Diabetes." Herbert H. Marks. New England Journal of Medicine, August 29, 1946.

HARRY HAMPTON DONNALLY, B.S., M.A., M.D., F.A.A.P.

(1877–1947)

Dr. Harry H. Donnally, distinguished Washington pediatrician, died May 23 in a Baltimore hospital following a long illness. After discontinuing his practice in 1943 because of ill health, Dr. Donnally retired to his home at High Acres, 6450 Brooks Lane.

A native of Georgetown, Kentucky, Dr. Donnally was born September 4, 1877. He was the son of Dr. Williams Donnally and Martha Schaaff Donnally, and a descendant of Colonel Andrew Donnally, who founded Lewisburg, West Virginia. In 1880 the family came to Washington, where Dr. Donnally attended elementary school. He graduated from the old Central High School in 1893, and three years later received a Bachelor of Arts degree from Columbian College, now George Washington University. In 1897 he was awarded a Master of Arts degree from that school.

He studied under a normal fellowship at Gallaudet College, intending to become a teacher of the deaf. After a year of teaching at the Faribault (Minn.) School for the Deaf he returned to Washington to begin his medical education. He graduated with highest honors from the Columbian College Medical Department in 1903 and interned for a year at the University Hospital.

For several years he was associated with the late Dr. H. G. Yarrow. After deciding to enter private practice as a specialist in pediatrics, he enrolled in the Harvard Medical School in 1910. From 1912 to 1919 he served as a physician at semi-weekly clinics at the Harriet Lane Home of Johns Hopkins Hospital. Becoming interested in the causes of asthma in children, he took a course in allergy at the New York Hospital of Cornell Medical School in 1920. After his appointment to the Children's Hospital staff, he founded and for many years directed the Allergy Clinic. In addition to Children's Hospital, he was on the staff of Columbia, George Washington and Gallinger Municipal Hospitals. He served as attending physician at Columbia Institution for the Deaf for more than 30 years, and was consulting pediatrician at Glenn Dale Sanatorium.

Dr. Donnally was appointed to the staff of George Washington University School of Medicine as Instructor in Bacteriology and Pathology in 1905; in 1923 he was appointed Professor of Pediatrics and Executive Officer of the Department of Pediatrics. He was named Professor Emeritus of Pediatrics when he retired from teaching in 1943.

Along with his practice Dr. Donnally engaged in research on the diseases of children and contributed many papers to scientific journals describing his findings.

HARRY H. DONNALLY, M.D.

He was a Fellow of the American Academy of Pediatrics, serving for many years as Chairman of the Washington Chapter. He was also a Fellow of the American Medical Association, a Fellow of the American Academy of Allergy, a diplomate of the American Board of Pediatrics, and Past President of the Society for the Study of Asthma and Allied Conditions, now known as the American Academy of Asthma. He was elected to membership in the Medical Association of the District of Columbia in 1904 and in the District Medical Society in 1905; he became a Life member, January 1, 1945. Other scientific organizations of which he was a member were the Clinico-Pathological Society, the George Washington University Medical Society, the Washington Academy of Medicine, the Pediatrics Travel Club and Sigma Xi, honorary scientific fraternity.

He was affiliated with the St. Albans Episcopal Church. He was a charter member of the University Club, a member of the Chevy Chase Club, and a former member of the Sons of the Revolution.

Surviving are his wife, Mrs. Bessie Stearnes Donnally, and two sons, Harry H. Donnally, Jr., and Dr. Reaumur S. Donnally, who is a member of the District Medical Society. Two sisters, the Misses Marguerite and Dorothy Donnally, reside in Washington; one brother, Paul A. Donnally, lives in Madison, Conn., and two brothers, Charles W. and Carroll D. Donnally, are located in Los Angeles, Calif.

WALTER ASHBY FRANKLAND, M.D.

(1867–1947)

Lt. Colonel Walter Ashby Frankland, Medical Corps, U. S. Army, retired, died May 30 at the U. S. Naval Hospital, Bethesda, Md.

Dr. Frankland was born in Baltimore, Md., December 10, 1867. His father, Captain Walter E. Frankland, served in the Confederate Army during the War between the States.

After receiving his early education in the public schools of Washington, D. C., Dr. Frankland attended Georgia Military and Agricultural College at Milledgeville, Ga. He graduated from the Medical Department of Columbian University, now George Washington University, in 1896. He received postgraduate training in orthopedic surgery at Harvard Medical School.

Upon completing his studies, Dr. Frankland practiced in Washington for many years, serving also on the staff of Casualty and George Washington University Hospitals. In 1916 he enlisted in the Army; was commissioned a First Lieutenant in the Medical Corps at Plattsburg, New York; and between 1916 and the outbreak of World War I served as surgeon at Fort Meyer. Sent overseas in 1918, he was stationed at Tours, France, for more than a year. He returned to the United States with the rank of Major and was discharged from the service in 1919. The next year he was recommissioned a Lieutenant in the Reserve and served at Fort Meade, Md.

He was put on the inactive list of the Army Medical Corps in 1925, when he was appointed to the Public Health Service in Washington as surgeon. He retired from that position five years later because of ill health, and had lived since his retirement at 3754 Kanawha Street, N.W.

Dr. Frankland enjoyed yachting and was an Honorary member of the Capital Yacht Club, and the oldest member for several years.

He was a Fellow of the American Medical Association, a Fellow and Past President of the Washington Medical and Surgical Society, a member of the Association of Military Surgeons, the George Washington University Medical Society, and Phi Kappa Psi Fraternity. He was elected to membership in the Medical Association of the District of Columbia in 1899 and in the District Medical Society in 1906. In 1923 he transferred to Associate membership but was reëlected to Active the following year. He was a member of Cathedral Post No. 10 of the American Legion.

Mrs. Alice Pugh Frankland survives her husband, together with three sisters, Miss Mary Frankland and Mrs. Eva Wheatley, of Washington, and Mrs. Emily Bell of North Carolina.

HARRY THEODORE HARDING, M.D.

(1870–1947)

Dr. Harry T. Harding, Washington physician for more than 50 years, died May 28 at Garfield Hospital after an illness of several weeks.

Dr. Harding was born January 21, 1870, in Binghamton, New York, the son of Theodore A. and Caroline H. Harding. The family moved to Washington in 1881, where his father served as the YMCA director until his death in 1907.

After graduating from old Central High School in 1889, Dr. Harding attended Columbian University for one year. He then went to New York and entered the College of Physicians and Surgeons at Columbia University, receiving his medical degree in 1893.

From 1893 until his death he practiced in the Mount Pleasant section of Washington as general practitioner. He served as medical examiner during the Spanish American War and World War I.

A member of the American Medical Association, he was elected to membership in the Medical

Association of the District of Columbia in 1894 and the Medical Society in 1895, and had been a Life member since 1935.

He was a charter member of the Columbia Country Club and a former member of the Board of Trade and the University Club. An outstanding college athlete, he belonged to the Manhattan Athletic Club of New York and the Varsity "C" Club of Columbia University.

He is survived by his wife, Mrs. Ethel MacFarland Harding, who resides at 1401 Fairmont Street, N.W., and a brother, Clarence L. Harding, of Washington.

WILHELM EDMUND HARMON KRECHTING, A.B., M.D.

(1877–1947)

Dr. Wilhelm E. H. Krechting, a general practitioner in Washington for many years, died May 27 at his home, 1010 East Capitol Street, after a long illness. He had maintained his office at the same address.

Dr. Krechting was born in Amsterdam, New York, November 4, 1877. He received his A.B. degree from Princeton University in 1902, and his degree in medicine from Johns Hopkins University in 1906. After interning for two years at New York's Lying-in-Hospital and the J. Hood Wright Memorial Hospital, New York, he came to Washington at the suggestion of his cousin, the late Dr. Edward F. Pickford.

He was a Fellow of the American Medical Association, and an Active member of the District Medical Society since 1920. He was a member of the Lutheran Church of the Reformation and the Princeton Club of Washington.

He leaves his wife, Mrs. Helen M. Krechting, and a brother, Warren E. Krechting, of Washington.

COURTNEY MALCOLM SMITH, M.D.

(1899–1947)

Dr. Courtney M. Smith, National Medical Director of the American National Red Cross, was killed in an airplane crash, near Leesburg, Va., June 13, 1947.

Born in South Haven, Michigan, in 1899, Dr. Smith lived for a number of years in Everett, Washington. He graduated from the University of Oregon in 1933 and attended Yale University. Before the War he practiced in Juneau, Alaska.

He served during World War I as an Army private. During World War II, as Senior Surgeon with the U. S. Public Health Service, he was sent with the Army overseas on a strategic bombing survey.

He had been a Washington resident for four years, residing at 9901 Edgehill Lane, Silver Spring, Md. Prior to his appointment last year as National Medical Director, he had been associated with the Red Cross as Deputy Medical Director since 1944.

He was a Fellow of the American Medical Association and a member of the Oregon State Medical Society.

Surviving are his wife, Mrs. Evelyn C. Smith, and a daughter, Courlyne C. Smith; a brother, Irving Smith of Tillamook, Oregon; and two sisters, Mrs. David Hartley and Mrs. Pauline Speidel, Everett, Washington.

Headache—Chodoff and Blumenthal

(Continued from page 377)

28. Gottlieb, J. S.: Am. J. M. Sc., 1942, **204,** 553.
29. Engle, D. E., and Evanson, C. O.: Ibid., 1942, **204,** 697.
30. Blumenthal, L. S., and Rosenberg, M. H.: Data on use of benadryl, to be published.
31. Fromm-Reichmann, F.: Psychoanalyt. Rev., 1937, **24,** 26.
32. Gardner, J. W., Mountain, G. E., and Hines, E. A.: Am. J. M. Sc., 1940, **200,** 50.
33. Shelburne, S. A., Blain, D., and O'Hare, J. P.: J. Clin. Investigation, 1932, **11,** 489.
34. Rosenberg, E. F.: Arch. Int. Med., 1940, **65,** 545.
35. Steiner, S. A.: M. Ann. District of Columbia, 1945, **14,** 531.
36. Horton, B. T., MacLean, A. R., and Craig, W. M.: Proc. Staff Meet., Mayo Clin., 1939, **14,** 257.
37. Horton, B. T.: J.A.M.A., 1941, **116,** 377.
38. Spriggs, E.: Lancet, 1935, **2,** 1, 63.
39. Pelner, L., and Aibel, M. E.: J. Lab. & Clin. Med., 1942, **27,** 1546.
40. Horton, B. T., Magath, T. B., and Brown, G. E.: Arch. Int. Med., 1934, **53,** 400.
41. Shannon, E. W., and Solomon, J.: J.A.M.A., 1945, **127,** 647.
42. Bowers, J. M.: Arch. Int. Med., 1940, **66,** 384.
43. Karl, R. C., Peabody, G. E., and Wolff, H. G.: Science, 1945, **102,** 12.
44. Fay, T.: Pennsylvania M. J., 1941, **44,** 861.
45. Davidoff, L. M.: Tr. Am. Neurol. A., 1944, **70,** 176.
46. Davison, F. W.: Laryngoscope, 1945, **55,** 52.
47. Proetz, A. W.: Tr. Am. Acad. Ophth., 1944–45, **49,** 18.
48. Costen, J. B.: Ann. Otol., Rhin. & Laryng., 1944, **53,** 655.

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MEDICAL ANNALS
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THE TREATMENT OF ACUTE (OBSTRUCTIVE) CHOLECYSTITIS*

CHARLES S. WHITE, M.D., Sc.D., F.A.C.S.
Washington

A DISEASE or illness which may be treated successfully both medically and surgically cannot be sharply differentiated into two types of treatment, and it is not possible to designate this disease as medical cholecystitis and surgical cholecystitis. When the day arrives on which we can sharply divide our therapy without any overlapping, the art of medicine will receive a severe blow.

There is no unanimity in the treatment of acute cholecystitis, and, as a matter of fact, the definition of acute cholecystitis is somewhat vague and could be responsible for the diversity of opinions regarding its treatment. It is possible that the various contributors to our literature are not writing about exactly the same thing. Acute cholecystitis in Boston may not be acute cholecystitis in Los Angeles, with due respect to both.

For the purpose of this discussion I am considering only acute obstructive cholecystitis and with no effort to insert a wedge between the medical and surgical approach. It is a common ground that demands common sense. Fleeting attacks of cholecystitis or mild exacerbation in the course of chronic inflammation of the gall bladder, with few constitutional symptoms of brief duration, is not the type of cholecystitis under consideration. These remarks are directed to that acute infection which is pathologically distinguished by an obstruction of the cystic duct by stone, tenaceous thick bile, or by inflammatory exudate which eliminates the cystic duct as an avenue of drainage for the infectious contents of the gall bladder. The resulting intravesical pressure may be followed by rupture or gangrene in 10 to 15 per cent of the cases. It would not be improper to term it fulminative cholecystitis. It is of this type of cholecystitis that an effort has been made to prescribe the surgical treatment, even standardize it; and it is discussed as the immediate or the delayed operation. If the authors were writing about the identical pathology, they would not be so far apart.

I have endeavored to abstract the outstanding literature and hope that a fairly clear presentation will be an aid in arriving at a sound decision. No less a body than the United States

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*Presented at the Second Intensive Postgraduate Course, George Washington University School of Medicine, February 17, 1947.

Supreme Court has reversed itself, and many of its most far-reaching and important decisions have been based on a 5 to 4 vote. Let us not be too sure, then, that we shall add a note of finality in this discussion.

It is not essential to offer a dissertation on the etiology of acute obstructive cholecystitis except to state that the prevailing opinion considers it of hematogenous origin, although retrograde extension from the duodenum by the way of the common duct is possible.

The disease may be described as one with an acute onset which, after a few hours, is well established. Females are more prone to be victims than males, in the ratio of 2 to 1 to 3 to 1, and in a large group of tabulated cases from various sources it appears that 60 per cent of all cases range from 50 to 70 years of age. The pain is deep and boring, not colicky, concentrated beneath the middle of the right costal border and radiating to the epigastrium and back. The soreness or tenderness often extends over the entire upper right quadrant of the abdomen. Nausea and vomiting are usually present. Fever accompanies the illness but is rarely alarmingly high, with acceleration of the pulse and moderate leukocytosis with an increase in the segmented cells. Most other constitutional symptoms associated with an infectious invasion are present. Tenderness is noted under the right costal border with splinting of abdominal muscles. In most cases a pear-shaped mass with its base directed downward can be palpated in this area.

If we could visualize a gall bladder acutely inflamed, it would appear as a distended, tense, congested organ with thick walls and edema about the cystic duct. Were it possible to peer inside, gall stones would be seen in almost every case, the bile would be greenish black, tenaceous, and thick. Commonly the gall bladder is partially covered by an injected omentum which can be peeled off without much resistance.

Assuming that the course is uninterrupted by successful medical and surgical measures, we would observe increased tension and distention of the gall bladder, the contents becoming distinctly purulent, and further adhesions to the omentum, colon, or duodenum. At this point we may expect perforation of the viscus into the embracing omentum, or into the peritoneal cavity, the duodenum, colon, liver, or even externally. Another possible sequence is gangrene of the gall bladder with its portentous consequences. Cowley and Harkins[1] from a study of the literature found that 13 per cent of obstructive cholecystitis was followed by rupture. Blumberg and Zisserman[2] noted 20 deaths in 82 cases of acute suppurative or gangrenous cholecystitis and 7 deaths in 21 cases of ruptured cholecystitis. Of these 103 cases death occurred in 13 without operation; and, strange as it may first appear, cholecystostomy had over 3 times the mortality of cholecystectomy. This is understandable when it appears that the poorest risks were subjected to cholecystostomy.

Obstructive cholecystitis should not be confused with acute biliary colic, which may begin with severe colicky pain, vomiting, leukocytosis, fever, and local tenderness, but will subside in a few hours upon dislocation of the stone or after use of sedation and antispasmodics. It has been convenient for the purpose of argument to compare the gall bladder in most respects to the appendix and consider the treatment identical, namely, immediate surgery. This position is not altogether tenable because the appendix has not the same capacity to distend or empty itself in a measure. The gall bladder can tolerate greater relative distention than the appendix, and this property may serve to tide the patient over a short critical period. Notwithstanding the ability of the gall bladder to tolerate great intravesical pressure, rupture of the gall bladder, when acutely obstructed, occurs in 1 case out of 8, but there is no reliable criterion by which that particular accident can be anticipated. In the absence of any guidepost for such a decision we must search for a formula which may be helpful.

Those who have been voluble on this subject have set up a deadline for operative treatment, which in the abstract may seem logical but at the bedside leaves much to be desired. It is their rule to operate within the first 48 hours, or 72 hours at the most, in all cases of acute obstructive cholecystitis. This rule presents some difficulties in application. Many patients are not seen by the surgeon until 48 hours have elapsed, especially those patients who live in rural districts. Occasionally the onset cannot be accurately fixed, and the pathology does not proceed on a fixed schedule. One who follows the plan that prescribes surgery within 48 hours and turns to conservative treatment after that period, probably believes implicitly that planes and trains always arrive and depart on time.

When one attempts to align those in favor of early operation versus delayed operation, we find such names as Haggard, McGuire, Deaver, and Judd advocating postponing the operation until the acute symptoms subside. Judd later went over to the early operation, and the number of outstanding surgeons who accept his principles is apparently increasing. Clagett[3] is an early operator and bases his opinion on a very wide experience. McGuigan[4] found in an analysis of his 123 cases that the mortality rate after delayed operation was 2.3 per cent against 12.7 per cent after immediate operation. Glenn[5] reports a mortality of 5.14 per cent in 175 patients over 49 years old and only 1.13 per cent in 352 cases under 50 years old in which the practice of early operation was followed. These pros and cons could be multiplied many times by a systematic search of the literature but would fail to explain the disparity in the mortality. To rationalize the treatment of acute obstructive cholecystitis, there are a few factors that should be weighed before arriving at a decision.

The attack is well advanced in many cases when first seen by the surgeon. Not infrequently the patient treats himself a brief while for acute indigestion; the physician may temporize; and hospitalization is often delayed for various reasons, thus permitting the elective time for operation to escape even the eager surgeon.

Time is frequently lost in obtaining an adequate check-up, which means a thorough physical and various laboratory examinations. It should be obvious that most of these patients have passed their fifth decade and that diabetes and arteriosclerosis are not unusual complications.

Assuming the patient is seen shortly after the onset of an acute attack and the diagnosis of obstructive cholecystitis has been made, that he is a fair risk, what are the indications for the immediate operation or the delayed operation? The symptoms and signs should be considered collectively. The single leukocyte count in itself does not evaluate the pathology, but a steady rise in the count and an increasing shift to the left are significant. The temperature rarely exceeds 103° F., but a continuous high fever or a spiking temperature is not a good omen. A palpable sensitive mass under the right costal border that shows no tendency to recede should suggest a distended, inflamed organ. If vomiting persists and if chills occur we have incriminating evidence. In the presence of the symptoms noted above, an operation, in the light of the present practice, in our opinion, should be advised. A few hours' delay to prepare the patient should not be considered time lost. The use of parenteral fluids, blood transfusions, and chemotherapy more than repays for the time consumed in their administration. Even though the condition of the patient may seem critical, much may be gained by preoperative preparation; and the present low mortality is due in no small part to this wise therapy.

The choice of the anesthetic should be left to a competent anesthetist. I believe spinal anesthesia plus sodium pentathal is generally preferred. The type of incision is not important.

Cholecystectomy is unquestionably the operation of choice; and often the gall bladder can be removed with astonishing ease, since the lines of cleavage may be better defined by a mild inflammatory infiltration. Edema about the cystic duct may present difficulties in identifying and safely ligating the duct and cystic artery, and the presence of hyperemic and friable adhesions may be an additional problem. The decision to drain or remove the gall bladder can be made only at the time of operation and is not always an easy one, and the postoperative course often proves it. Although drainage alone is of less magnitude, it merely tides the patient over a grave emergency many times and leaves a pathologic setup for future attacks of cholecystitis.

The higher mortality of cholecystostomy shown by many reporters is not a true reflection of the risk, since there can be but little doubt that this operation is reserved for the critical cases. Those that recover can look forward to a second operation or recurrence of the primary illness in over 50 per cent of the cases. Those who recommend the delayed treatment qualify such a recommendation with the provision that the case should be observed from its clinical inception and the operation deferred if the symptoms subside and an afebrile status is maintained. An elective operation will have a very low mortality.

The trend toward the early operation, preferably cholecystectomy, must be recognized; but it does not seem possible or sane to adopt a fixed rule for the surgical treatment of a pathologic condition that cannot be visualized, and the infallibility of the signs and symptoms is still a fond hope. Many of us recall the impression made by Oschner's plea for the interval operation for appendicitis. It is now honored in its memory, rather than its application.

The inroads of chemotherapy upon operative surgery have been challenging but wholesome; and it is possible that in the not too distant future many of our practices, particularly in respect to the time element, may be radically modified by the drugs we now employ or by some unnamed substances still unborn in the laboratory of the biochemist.

I admit a failure to clearly differentiate those cases which require an immediate operation and those in which surgery may be deferred. It must depend upon the judgment of the surgeon, who in turn must count upon his greatest assets, experience and skill.

BIBLIOGRAPHY

1. Cowley, L. L., and Harkins, H. N.: Perforation of gall bladder; study of 25 consecutive cases. Surg., Gynec. & Obst., 1943, **77**, 661.
2. Blumberg, N., and Zisserman, L.: Acute suppurative and gangrenous cholecystitis. Am. J. Surg., 1945, **70**, 38.
3. Clagett, O. T.: Diseases of gall bladder; diagnosis and management. S. Clin. North America, 1945, **25**, 929.
4. McGuigan, W. J.: Acute cholecystitis; comparative study of mortality rate after immediate and delayed operations. Am. J. Surg., 1945, **68**, 219.
5. Glenn, F.: Surgical treatment of acute cholecystitis. Bull. New York Acad. Med., 1946, **22**, 284.

DIAGNOSIS AND MEDICAL MANAGEMENT OF GALL BLADDER DISEASE*

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Gall bladder disease is a frequent cause of ill health and particularly so in the age groups between 40 and 60 years. Its importance is more striking when we consider that about 60 per cent of people who consult a physician do so because of abdominal discomfort or "indigestion," and 20 per cent of these cases with "indigestion" as the chief complaint have gall bladder disease. There are many affections of the gall bladder, some of which give a clear-cut clinical syndrome while others present a vague symptomatology requiring comprehensive studies to establish an accurate diagnosis.

The most frequently observed types of gall bladder disease are acute cholecystitis, chronic noncalculous cholecystitis, and cholelithiasis.

Acute Cholecystitis

Acute cholecystitis comprises about 20 per cent of all diseases involving the biliary tract. The pathologic lesions in the gall bladder are very changeable and may range from the mildest inflammatory reaction with edema to extensive gangrene or perforation, and these transitional stages are difficult to predict. When acute cholecystitis exists in a severe or complicated form the patients are usually hospitalized in order that the clinical picture can be more clearly evaluated. At the Doctors Hospital in Washington, D. C., during a 5-year period there were 120 patients admitted with the diagnosis of acute cholecystitis, and of this number, 92 or 70.6 per cent were females, and 28 or 29.4 per cent were males. The majority of these patients were in the 60-year age group. A significant proportion, however, 30.4 per cent, were less than 40 years of age. The oldest patient was 89 and the youngest 26. In the majority of cases of acute cholecystitis an obstruction is usually present in the cystic duct, and in approximately 90 to 95 per cent of the cases the obstructing agent is an impacted calculus. This blockage of the cystic duct causes an accumulation of the normal secretions and distention of the gall bladder. If the intravesicular pressure progresses, the vascular supply in the wall of the gall bladder will be seriously impaired, and ischemia with necrosis, gangrene and perforation may follow.

The clinical manifestations of acute cholecystitis are extremely variable and often fail to represent the true underlying pathology. When characteristic, however, there is severe, continuous boring pain in the right upper quadrant of the abdomen. The pain may be referred to the midscapular or right scapular region either by direct extension or radiation around the right costal margin. The attack usually begins suddenly about 5 hours after eating a heavy meal containing rich foods, and nausea, vomiting, fever and leukocytosis frequently accompany the pain. Early in the attack the temperature and leukocyte count are only slightly elevated, and these features significantly emphasize the fact that acute cholecystitis is primarily obstructive, rather than inflammatory in nature. After about 48 hours the sterile bile may become infected and result in a rapid elevation of the temperature, pulse and leukocyte count. On abdominal examination the maximum point of tenderness is over the anatomic location of the gall bladder, and the overlying muscles are tense and "on guard"; in addition, compression tenderness over the lower thoracic cage when present is an important diagnostic sign of acute cholecystitis. A valuable and highly significant finding is the palpation of a large tender gall bladder in the right upper abdomen. Repeated observations of this mass to note any change in size or position will often disclose whether the acute process is advancing or subsiding.

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Clinical jaundice is present in about 25 per cent of cases of acute cholecystitis, and the icterus index denotes the degree of bilirubinemia. In a patient who is critically ill the determination of the serum amylase and serum lipase may be the only means of establishing the onset of a complicating acute pancreatitis. At times pancreatitis may be suspected if the urinalysis reveals glycosuria and the blood sugar is elevated. If acute cholecystitis is prolonged, additional laboratory tests, such as the prothrombin time and protein and cholesterol concentrations in the blood may be found extremely valuable. The X-ray findings in acute cholecystitis may be equivocal, although a flat film of the abdomen which shows a shadow indicating a stone or stones in the gall bladder area is almost positive proof of cholecystic disease. However, a negative report does not rule out disease, since all gallstones are not opaque to X-rays. Cholecystography is contraindicated because an acutely inflamed gall bladder is unable to concentrate or evacuate the dye. At times complications in acute cholecystitis occur very suddenly, and Berk[1] has stressed the frequency with which they appear. Gangrene of the wall of the gall bladder occurs in about 25 per cent of the cases, and perforation has been observed in 10 to 12 per cent. If all surgical reports of empyema as well as those in which the diagnosis was established by microscopic study are considered, empyema occurs on the average of 20 per cent of cases. When a pericholecystic abscess develops, it may remain localized or rupture into the peritoneal cavity with the formation of a generalized peritonitis. From 5 to 15 per cent of patients with acute cholecystitis show an associated pancreatitis at operation.

The diagnosis of acute cholecystitis is based chiefly on the clinical findings. Important features are a history of recurring attacks of biliary colic, severe upper abdominal pain and tenderness, a palpable, tender gall bladder, leukocytosis and fever. In the differential diagnosis the conditions most likely to cause confusion are coronary artery disease, acute pancreatitis, acute appendicitis and perforated peptic ulcer. A scout film of the abdomen, electrocardiogram, and estimation of the serum amylase are of aid in arriving at a correct diagnosis. When the complication of jaundice exists, the hepatogram as proposed by Hunter[2] may determine whether it is of extra- or intrahepatic origin.

The treatment of acute cholecystitis should be individualized and all clinical findings thoroughly evaluated. To accomplish this the patient must be hospitalized immediately and essential studies performed without delay. Although there is general agreement that surgical intervention is indicated, the time to operate has caused widespread controversy. Some surgeons advocate and emphatically urge immediate operation in every case of acute cholecystitis, after adequate preoperative preparation. They argue that early operation may prevent the occurrence of fatal complications. Other surgeons of the so-called "conservative" school think differently and contend that operation should be deferred until the acute process has subsided. They point out that surgery in the acute phase is often limited to a cholecystotomy with a subsequent operation becoming necessary and thus increasing the morbidity and mortality. To reconcile these opposing views is a difficult task.

A decision for immediate operation should be limited to those cases in which signs of impending perforation are manifested by high leukocytosis, rapidly rising temperature, and a large, tense and tender gall bladder. In the absence of these clinical findings, a conservative regimen is instituted which includes maintenance of the nutritional, fluid and electrolyte balance. Liquids in the form of water, broth, tea and sweetened fruit juices are given by mouth. If the patient has been vomiting, nothing is given orally and parenteral fluids are administered immediately, preferably by the intravenous route, in the form of 1,000 c.c. of 5 per cent glucose in normal saline solution, alternating every 12 hours with 1,000 c.c. of a protein digest mixture. If jaundice is present 5 mg. of vitamin K is given intramuscularly each day. Certain laboratory studies should be made which include a complete blood count, urinalysis, blood chemistry (including estimation of blood proteins, blood nonprotein nitrogen, serum amylase, blood sugar and blood chlorides), icterus index, van den Bergh test, prothrombin time, blood typing, and a flat film of the abdomen. If the prothrombin time is below 60 per cent of normal, operation should be deferred until it is elevated. Hypoprothrombinemia can be combated by the administration of whole blood transfusions and large amounts of vitamin K. For the relief of pain either codeine, ½ grain (0.03 gm.) with atropine sulfate, 1/100 grain, or pantopon, ⅓ grain (0.02 Gm.) have been found quite effective. If clinical signs indicate a subsidence of the inflammation, certain diagnostic studies are undertaken which include cholecystography and possibly diagnostic biliary drainage.

The patient is prepared for operation by prescribing a high caloric diet consisting of protein 25 to 35 per cent, carbohydrate 60 to 70 per cent, and fat 5 per cent or less. The diet is fortified additionally with vitamin concentrates, containing especially B complex and vitamins C and K. After adequate preoperative preparation the patient should have a cholecystectomy with exploration of the common duct.

Chronic Noncalculous Cholecystitis

The diagnosis and medical management of chronic gall bladder disease without stones presents problems equal to those seen in acute cholecystitis. As the criteria for a diagnosis of chronic cholecystitis have become more exact the disease is less frequently found to be the cause of subjective complaints. The etiology of chronic cholecystitis has not been definitely determined, although it has been held that infection is the primary cause. However, there is recent evidence demonstrating that trauma, bile stasis, or chemical abnormality of the bile may be the initiating factor in the disease, with infection assuming a secondary role.

Pathologically, various grades of inflammatory reaction may be noted in the gall bladder and involve the cystic duct to cause partial occlusion. Pericholecystic adhesions may bind the viscus to neighboring structures.

The symptoms of chronic noncalculous cholecystitis are often vague and inconclusive. Occasionally, if there is reflex spasm of the sphincter of Oddi or obstruction of the cystic duct the classical symptom-complex of "biliary colic" may occur. If the attack follows the ingestion of a heavy fatty meal it favors cholecystic disease and warrants further investigation of the gall bladder. More frequently, however, the symptoms are less convincing, and particularly so when the attacks have been of a minor degree. In addition, it should be emphasized that the symptoms of upper abdominal distress with belching, bloating and borborygmi are not to be attributed to chronic gall bladder disease without exhaustive diagnostic studies, which include a careful roentgenologic examination.

Illustrative Case

A female aged 32 with a past history of excellent health until her present illness on December 15, 1946 complained of intermittent upper abdominal discomfort, postprandial belching and bloating, and constipation which had been present for 6 weeks. At the onset of her symptoms she was seen by her physician who had X-ray examinations of the gall bladder and gastrointestinal tract made. She was told that the gall bladder failed to fill with the dye and that the gastrointestinal tract was negative, and cholecystectomy was advised. Seeking confirmation of these findings she requested further examinations. Subsequent studies revealed an enlarged tender liver, and the routine protosigmoidoscopic examination disclosed fecal material mixed with dark blood without visible evidence of ulceration or tumor. A second roentgenographic examination of the gastrointestinal tract including cholecystograms showed fair filling of the gall bladder and a partially obstructing malignant growth in the lower sigmoid colon. At operation there was a large fungating carcinoma of the lower sigmoid and extensive metastases to the liver.

Oral cholecystography is an important aid in the diagnosis of chronic noncalculous cholecystitis. By this means it is possible to study the ability of the gall bladder to concentrate and respond to fat stimulation. Absent or faint shadow must be interpreted together with the clinical history and associated findings. In the absence of symptoms directly referable to the gall bladder[3] lack of visualization alone cannot be accepted as positive proof of cholecystic disease, since under certain conditions, notably the presence of duodenal ulcer, the dye fails to concentrate the dye-laden bile sufficiently for positive findings. If the clinical findings of cholecystic disease are definite but the cholecystograms are indecisive, one may resort to diagnostic biliary drainage and a second cholecystographic examination in order to obtain more information. A careful microscopic study of the bile is valuable, and when cholesterol crystals, calcium bilirubinate pigment or both substances are found they point strongly to the presence of gall bladder disease.

In the treatment of chronic noncalculous cholecystitis it is imperative that all findings be carefully appraised, and any associated dysfunction of the gastrointestinal tract should receive appropriate attention.

The treatment of chronic cholecystitis is primarily a medical problem, as the percentage of surgical failures in this group of cases is often as high as 50 per cent. The highest incidence of unsatisfactory results appears to follow the removal of the noncalculous gall bladder, where there was no history of colic. In the medical management of chronic noncalculous cholecystitis, cholagogues and choleretics are indicated. It is definitely established now that the former agent possesses the property of stimulating gall bladder evacuation while the latter increases the flow of bile. A diet high in fat is probably most effective in producing good emptying of the gall bladder, and the administration of bile salts and bile acids increases the volume of bile flow. Where spasm and pain are factors, relief may be obtained by using phenobarbital and atropine or atropine derivatives such as belladonna. In the presence of severe colicky pain due to biliary dyskinesia instant relief often occurs following the inhalation of amyl nitrite.

CHOLELITHIASIS

It has been conservatively estimated[4] that about 10 per cent of adults in the United States either have cholelithiasis or are potential stone-bearers. Cholelithiasis may be an accidental finding and present no symptoms, or it may mimic or actually mask almost any disease of the chest and abdomen. The most characteristic symptom of cholelithiasis is "biliary colic" or pain in the right upper abdomen. The attacks may be severe or mild and occur at irregular intervals. The typical attack commonly begins in the late evening or early morning with severe, continuous, knife-like pain in the right upper abdomen, restlessness, nausea and vomiting. Upon physical examination there are marked tenderness and muscular resistance over the gall bladder area. The past history may disclose symptoms of a deranged digestion characterized by belching, bloating and flatulency.

In the diagnosis of cholelithiasis, the most important single laboratory aid is X-ray examination of the gall bladder. Flat films of the abdomen show gallstones containing sufficient calcium to render them radiopaque, and when found have great positive value. However, a negative finding under such circumstances has no diagnostic significance. Cholecystography[3] following the administration of the dye carries a very positive value in the recognition of cholelithiasis and cholecystitis. When the dye enters the gall bladder and shows fair concentration, stones will be revealed as negative shadows in more than 90 per cent of the patients in whom they are present. Lack of visualization of the gall bladder must be interpreted in the light of the clinical history and associated findings. In the presence of colic it usually means cystic duct obstruction which in the vast majority of instances is calculous in character. In a very small percentage of cases, gall bladders which following the administration of the dye have shown normal function may contain stones. Where cholecystography is indecisive, the presence of calculi may be established by microscopic study of the bile. Bockus[5] demonstrated the value of bile microscopy in gallstone diagnosis. Operation revealed the presence of gallstones in 31 of 34 patients whose bile obtained by nonsurgical duodenal drainage contained calcium bilirubinate pigment but no cholesterol crystals, an accuracy of 90 per cent in the positive diagnosis of cholelithiasis. The occurrence of both cholesterol crystals and calcium bilirubinate pigment in the same bile was noted in 72 patients, and at operation 100 per cent of them showed gallstones.

In the treatment of patients with cholelithiasis certain therapeutic measures may be employed. During a mild attack of biliary colic the inhalation of amyl nitrite may abolish the discomfort, but when the pain is severe it becomes necessary to administer morphine sulfate, $\frac{1}{4}$ to $\frac{1}{2}$ grain, for complete relief. The patient should be observed carefully to detect the onset of complications. If the attack subsides, water, fruit juices and buttermilk may be allowed in small amounts and the diet gradually enlarged if progress is satisfactory. Certain dietary restrictions are to be invoked if attacks are to be prevented or reduced to a minimum. The avoidance of fats, fried foods, and overeating are to be emphasized. In general the diet most suitable is one containing proteins, carbohydrates and adequate vitamin content. It is further desirable to reduce the total caloric intake when obesity is a factor.

Unless contraindications exist the treatment of cholelithiasis in most instances should be surgical, because one cannot predict with certainty when complications may occur in the gall bladder oı neighboring structures. Occasionally gallstones are discovered in patients who have no symptoms from them, and uncertainty arises about the best course to follow. Under these circumstances it becomes necessary to carefully appraise all clinical findings before making a decision.

BIBLIOGRAPHY

1 Berk, J. E.: Management of acute cholecystitis. Am J. Digest. Dis., 1940, **7**, 325.

2. Hunter, O. B : Personal communication.

3. Abell, I.: Surgical aspects of chronic dyspepsia. Kentucky M. J., 1945, **43**, 70.

4. Bockus, H. L., and others: Gastroenterology, vol. 3. Philadelphia: Saunders, 1946.

5. Bockus, H. L., Shay, H., Willard, J H., and Pessel, J. F.: Comparison of biliary drainage and cholecystography in gallstone diagnosis, with especial reference to bile microscopy. J.A.M.A., 1931, **96**, 311.

GALLSTONE OBSTRUCTION OF THE INTESTINE*

A Brief Review of the Literature with Report of Four Cases

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THE first recorded case of intestinal obstruction due to gallstones was reported by Bartholin[1] in 1654. In 1914 Wagner,[2] from a study of the literature, tabulated 334 cases. In 1925 Moore[3] estimated that 400 cases had been reported, and since then many more have been added.

Estimates as to the frequency of this condition vary from 0.4 to 5 per cent of all cases of intestinal obstruction. Powers[4] in his excellent review stated that the frequency is about 2 per cent. Taking into account the number of unreported cases which must occur, the true incidence is probably greater. Thus, obstruction from this cause is by no means rare, but diagnosis is seldom made before surgery or autopsy.

As would be expected, most cases occur in elderly patients, and it is more common in women (Marshall and Mitchell[5]), since gallstones occur more frequently in the female and their incidence increases with age. Hinchey[6] reports an average age of 66 years. In the 4 cases reported here the youngest patient was 47 and the oldest 67.

Cholecystitis and cholelithiasis are followed by ulceration, erosion and pericholecystitis. Adhesions then occur between the gall bladder and the surrounding viscera, and perforation follows. Usually this takes place between the gall bladder and the duodenum, but occasionally the stomach, jejunum, ileum, colon, and even the urinary bladder are involved. This is the common sequence of events, but cases have been reported in which the stone passes by way of the biliary ducts into the intestine through the ampulla.

In most cases in which the location of the obstruction was mentioned, it was within 2 feet of the ileocecal valve (McQueeney[7]). In our cases the obstructing stone was found in the sigmoid in 2 instances and the jejunum in 1. In the remaining case the exact site is not recorded beyond the mention of small intestine.

Usually cholecystoduodenal fistula exists as evidence of erosion of a stone into the bowel without obstruction, the majority of stones ulcerating into the bowel being passed by rectum.

Gallstone ileus is an obturation form of obstruction. Most stones begin their course through the bowel in the relatively wide duodenum and are usually arrested in the ileum where the lumen is much smaller. If the ileocecal valve is passed the stone usually will go through the colon without ever causing obstruction because of the large diameter of this portion of the tract. Consequently, the size of the stone is the most important single controlling factor determining the point of obstruction. However, many other factors exist which influence the site of the obstruction; sharp edges of the stone, kinks of the bowel, anomalies of bowel lumen, slow peristalsis, and trauma to the bowel wall from passage of the stone all enter the picture. Obstruction may be intermittent for a time before the stone is finally stopped in its passage and the obstruction becomes complete.

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Symptoms may be placed in three groups corresponding to the pathogenesis of the condition[6]:

1. Symptoms of gall bladder disease, frequently mild and of long duration.
2. Symptoms due to the passage of the stone from the gall bladder into the intestinal tract.
3. Symptoms of intestinal obstruction as the presenting clinical feature.

In many cases 1 and 2 above may be missing, although careful questioning usually may elicit a "gall bladder history." It is surprising how often passage of the stone into the bowel is unattended by striking symptoms.

The usual history is that of sudden, complete, acute intestinal obstruction or recurrent attacks of partial obstruction in a patient with a longstanding history of gall bladder disease. Visible peristalsis rarely is present, local tenderness is not marked, and the premonitory signs, in general, are not striking. Thus, the equivocal character of the symptoms often causes delay in surgery and adds to the high mortality rate.

The correct diagnosis seldom is made prior to surgery or autopsy. In none of our cases was the diagnosis made preoperatively. Admittedly a correct clinical diagnosis is difficult and often impossible to make. However, the incidence of this form of intestinal obstruction is high enough so that the possibility of its existence in any given case must be thought of in the differential diagnosis. Careful questioning of the patient often will elicit the antecedent history of gall bladder difficulty and make the diagnosis of gallstone ileus a possibility. Perhaps increasing awareness of this entity will lead to earlier treatment with consequent lowering of mortality.

X-ray examination offers one of the more accurate methods of diagnosis. Rigler, Borman and Noble[8] state that "in most instances an exact diagnosis of dynamic ileus due to gallstones can be determined by means of roentgen examination." This type of examination may reveal any or all of the following:

1. Air from the intestine in the bile ducts.
2. Injected contrast medium in the biliary tree.
3. Direct visualization of the stone or indirect visualization by means of contrast medium in the intestine.
4. Change in position of a previously reported stone.
5. X-ray evidences of intestinal obstruction.

The treatment is surgical as early as patient's general condition permits, and the operative procedure should be limited, generally, to the relief of the obstruction. Cholecystectomy seldom should be considered, for it unduly prolongs the operation. The gall bladder may be removed at a later date if necessary. Usually removal of the stone and enterostomy suffice. With obstruction of only short duration the bowel often may be closed immediately.

Hinchey advises surgery when it becomes evident that the stone has stopped in its downward course and obstruction is more or less complete. The only time when delay may be justified is when obstruction is more or less intermittent and there is still the possibility that the stone will pass by rectum. Then decompression by use of a Miller-Abbott tube, general supportive measures, and watchful waiting are advocated.

Marshall and Mitchell advise making the incision through healthy bowel just beyond the point of obstruction, and milking the stone down to this point. This avoids the hazards of suturing edematous, dilated, thin bowel wall.

REPORT OF CASES

Case 1.—C. W., a white female aged 65, was admitted January 14, 1937, complaining of cramplike pains across the lower abdomen and constipation. A week before admission she had developed pain in the left lower quadrant near the mid-line and passing across the abdomen above the symphysis to the right lower quadrant. At first it was not very severe, but gradually it increased in severity and was cramplike at the time of admission. At the same time she began to lose her desire to eat, and on admission she had no appetite at all. Forty-eight hours before admission she vomited 2 "Feen-a-mints" which she took for constipation She had been unable to have a bowel movement for 3 days. Before this her bowels had always been regular and her appetite good.

Examination revealed the abdomen to be distended and tense. Upon percussion a wavelike movement extended across the abdomen in its lower half. A suggestive mass was felt in the right lower quadrant. Extreme pain was present on deep palpation. Percussion sounds were tympanitic over the upper abdomen but dull over the lower abdomen.

On the following day a laparotomy was performed. An annular mass $\frac{3}{4}$ inches long was felt involving the sigmoid. Both large and small bowel were distended. The cecum was decompressed by a catheter, and the incision was closed with a view to subsequent surgery on the left side.

On February 2 another operation was done. Through the left rectus incision the mass was freed from its peritoneal attachments and brought to the outside of the abdominal wall and covered with vaseline gauze.

Several days later a second stage Heineke-Mikulicz operation was done, at which time the sigmoid "growth" was removed by cautery. On opening the specimen, two large hard stones almost the size of a hen's egg were found. They had ulcerated the mucous membrane and perforated the bowel in 2 places.

The patient made an uneventful recovery and was discharged March 17.

Case 2.—M. M., a white female aged 47, was admitted on April 29, 1945. Two days before admission she had started to have abdominal cramps. She took a soda enema and the pains got worse. The next day she started vomiting and vomited all day. She took nothing by mouth and the pain gradually subsided until on admission, when she was conscious of mild abdominal pain.

Examination revealed a somewhat distended abdomen which was quiet on auscultation and not tender to palpation. Otherwise the physical examination was negative. Routine laboratory tests showed a white blood cell count of 19,500 with a normal differential. Other tests were within normal limits.

On May 1 a laparotomy was performed. Through a mid right rectus incision the dilated small bowel was delivered into the operative field. At the mid portion of the jejunum a large gallstone about the size of a golf ball was found impacted in the lumen of the gut. Above the stone the bowel was dilated and below the stone it was constricted. The stone was removed through a longitudinal incision and an enterostomy tube left in the wound.

On May 28 another operation was performed. The bowel leading from the ligament of Treitz to the point of ileostomy was somewhat dilated, indicative of mild obstruction. The bowel distal to the site of enterostomy was collapsed. The jejunum was divided 6 to 8 inches from the point of the enterostomy and the divided ends closed. An anastomosis was performed between the proximal loop and the loop of the jejunum distal to the enterostomy, short-circuiting the fecal flow around that point. The wound was closed routinely without drainage.

Except for a slight rise in temperature, pulse and respiration 3 days postoperatively the course in the hospital was uneventful and she was discharged as recovered on June 17.

Case 3.—A white female aged 55 was admitted on January 26, 1946, complaining of vomiting and constipation. Several days prior she had started to become constipated. One or two days later she had begun to vomit after every meal. She had abdominal pains which felt like gas pains at the time. These persisted until her admission. She never passed any blood. The past history was essentially negative.

The abdomen was distended and painful to palpation. The liver, kidneys and spleen were not palpable. No masses were felt. Routine laboratory examinations were all within normal limits. A diagnosis of partial intestinal obstruction, etiology unknown, was made. A Wangensteen was inserted and there was no further vomiting. She passed gas by rectum but no feces, and a soapsuds enema was ineffective.

On February 4 operation was performed. The obstructed bowel was delivered through a low right rectus incision. The cause of the obstruction was found to be a large, irregular, hard stone, about the size of a walnut, in the small bowel. The bowel was opened. The stone was broken up and removed in pieces. Apparently it was a gallstone. The incision in the bowel was closed without enterostomy. The gall bladder could not be identified because a piece of small bowel was firmly adherent by numerous adhesions to it and the liver. Recovery was uneventful and she was discharged on February 28.

The stone was "an irregularly shaped piece of stony material 3 cm. in diameter. It is hard and when cut resembles a bilirubin, cholesterin, calcium stone, the origin of which is probably the gall bladder."

Case 4.—A white female aged 67 was admitted on May 25, 1938, complaining of moderately severe abdominal pain and a foul-smelling brown vaginal discharge. Several weeks prior to admission she had developed pain across her entire abdomen. At that time she had had slight indigestion, but the bowel movements were regular. She paid no attention to this because she was always subject to bouts of indigestion. A few days after the onset, a dark brown, foul-smelling vaginal discharge began. This had continued for 5 weeks until the time of admission, but at that time it was diminishing and becoming lighter brown.

Fifteen years before she had had 3 severe attacks of "appendicitis" which were treated symptomatically with occasional residual pain.

She was dyspneic on moderate exertion and stated that recently she noticed that her ankles were swollen at night.

Examination revealed moderately severe tenderness in the epigastrium and both lower quadrants. An enterovaginal fistula was found.

The roentgenologist reported: "From vaginal and X-ray examinations one is inclined to believe that the fistula is either from a ruptured appendix or from a ruptured diverticulum of the sigmoid. On X-ray examination no definite evidence of fistula was seen. The patient was not coöperative, and a good examination was not possible."

On July 12 an exploratory laparotomy was done and what was thought to be a broad annular carcinoma was found in the mid portion of the sigmoid. It was plastered to the side of the vagina, and a fecal fistula had spontaneously formed. Because of the patient's poor condition, it was thought unwise to deliver the mass and the abdomen was closed.

The patient remained in the hospital receiving symptomatic and supportive treatment. Her course, however, was gradually but inexorably downward and she died on November 6.

An autopsy was performed which revealed the following gross finding in the gastrointestinal tract:

"The duodenum was firmly adherent to the gall bladder and, when separated, a well-formed fistula was revealed between it and the fundus of the gall bladder. In the lower pelvis the sigmoid, rectum and reproductive organs were removed intact. The rectum and sigmoid were opened longitudinally. A large stone 3.5 by 3.0 cm. was encountered impacted at the sigmoidorectal junction, embedded in a necrotic fossa. The wall surrounding this fossa was considerably thickened but the overlying mucosa was not involved. The vagina was opened and an opening readily seen in the posterior vault. A probe was passed through this opening, and a sinus tract was revealed extending from this point to the fossa containing the stone in the sigmoid. The appendix was grossly negative. The gall bladder contained a stone 2 by 2 cm." Microscopic reports were negative.

SUMMARY AND CONCLUSIONS

1. Four cases of gallstone obstruction of the intestine are presented, together with a brief review of the literature.

2. The excessively high mortality rates reported from this condition probably could be decreased if the entity were kept in mind in the differential diagnosis.

3. X-ray examination may be helpful in preoperative diagnosis.

4. Treatment is surgical with the type of procedure depending upon the patient's general condition. Proper supportive measures are of greatest importance.

5. Successful management depends on early diagnosis and prompt treatment.

BIBLIOGRAPHY

1. Bartholin, cited by Mar'in, F.: Intestinal obstruction due to gallstones; with report of 3 successful cases. Ann. Surg., 1912, **55**, 725.
2. Wagner, A.: Ileus durch Gallensteine. Deutsche Ztschr. f. Chir., Leipz., 1914, **130**, 353.
3. Moore, G. A.: Gallstone ileus. Boston M. & S.J., 1925, **192**, 1051.
4. Powers, J. H.: Acute intestinal obstruction due to impacted gallstones; report of 4 cases. Surg., Gynec. & Obst., 1928, **47**, 416.
5. Marshall, S. F., and Mitchell, B. D.: Symposium on gastrointestinal surgery; intestinal obstruction caused by impacted gallstone; report of 3 cases. S. Clin. North America, 1944, **24**, 648.
6. Hinchey, P. R.: Gallstone ileus. Arch. Surg., 1943, **46**, 9.
7. McQueeney, A. M.: Internal biliary fistulae and intestinal obstructions due to gallstones. Ann. Surg., 1939, **110**, 50.
8. Rigler, L. G., Borman. C. N., and Noble, J. F.: Gallstone obstruction; pathogenesis and roentgen manifestations. J.A.M.A., 1941, **117**, 1753.

HISTOPATHOLOGY, CHEMISTRY AND SUPPORTIVE TREATMENT OF BURNS

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NOT long ago we were inclined to treat the severely burned patient as a burn. We overlooked the most important fact of all that we had a most complex organism, the patient, suffering from burn damage in all his component parts. We further overlooked the old truths, pointed out by John Hunter in 1848, that we had no power to directly repair any injury; that it is the prerogative of Nature alone to repair the wastes of any structure. With this in mind, we see that our chief duty consists in ascertaining and removing those impediments which obstruct the reparative process or thwart the efforts of Nature, and thus enable her to restore the parts to their normal condition.

In order to help our patient we must understand his histopathologic and chemical state.

Pathologic Anatomy

Pathologic changes of a first-degree burn are essentially those of inflammation, namely, dilatation of vessels, exudation of fluid, and margination and exudation of leukocytes. In the repair of this minimal lesion, there may be desquamation and hyperpigmentation, which disappear in a few weeks.

In the second-degree burn there are all of the changes of a first-degree burn plus irreversible coagulation necrosis of the superficial epidermis. This state leads to the exudation of fluid into the epidermis and the formation of a vesicle. The fluid approximates the composition of blood plasma. In healing, epidermization occurs under the vesicle, and the integrity of the surface is restored.

In the third-degree burn the entire epidermis and a part of the dermis, except for the rete pegs, are destroyed. An inflammatory reaction takes place in the exposed dermis, and the surface is covered by a fibrinous exudate. The epithelium regenerates from the rete pegs, but there will be some scarring because of destruction of the superficial dermis and loss of some of the epidermal appendages.

The fourth-degree burn is characterized by destruction of tissue down to or into the subcutaneous fat and muscles. The burn appears as a brown eschar (dry heat) or a white, coriaceous area (moist heat, as by live steam). The immediately surrounding tissues show varying grades of first-, second-, and third-degree burns. After a varying number of days the necrotic tissue drops out and exposes the deeper tissues, which are the seat of an intense, acute inflammation. Repair is accomplished by proliferation of granulation tissue to fill the defect, and growth of epithelium from the edges. The epidermal appendages do not regenerate, and a scar, free of hair, sweat glands, and sebaceous glands, covered by an atrophic layer of epidermis, is the result.

Systematically there are hyperemic changes in all viscera, notably the brain and lung. In the kidneys there is a cloudy swelling and fatty degeneration of the epithelium, and occasionally thrombi in the smaller vessels. The adrenals are greatly enlarged, soft and red. The cortical cells may go on to necrosis. In the liver there is cloudy swelling, fatty degeneration, and central necrosis in the terminal stages. Acute ulcers of the stomach and duodenum are seen in some

2 to 4 per cent of patients with extensive third degree burns. These ulcers are sharply outlined and usually do not extend beneath the submucosa. With exposure of the free nerve endings in the dermis there is extreme pain.

The physiologic and chemical changes are those of shock, that is, a reduced total and effective blood volume; a reduced minute volume output of the heart, and volume flow of arterial blood; hemoconcentration and increase of the nonprotein nitrogen, glucose, and potassium in the blood; a reduction in metabolism, alkaline reserve, chloride, and oxygen content; delayed coagulability of the blood; and an increased flow of lymph in the thoracic ducts.

We must realize that our severely burned patient lives from hour to hour, and day to day, and that each period brings different problems. Treatment must be instituted before critical signs and symptoms appear, not afterward, because shock and degeneration always are hours ahead of clinical and laboratory tests. One should always consider extensive burns as critical injuries. It is far better to find that more than adequate care has been given to a moderate burn than it is to be confronted with a terminal emergency arising from inadequate treatment of a critical burn. If 25 per cent of the body is involved, and the patient shows any signs of shock, critical treatment should be instituted at once.

The following is a more or less Utopian résumé of the supportive treatment of a burned patient:

Duties of the Surgical Services.—See patient at once. Shock may be expected shortly, if not already present, in cases of infants up to 6 years old with an 8 per cent burn or more and children and adults with a 15 per cent burn or more. Occasional sick or very feeble patients may have shock with smaller burns. All burns of these extents should have prompt intravenous treatment even if the temperature, pulse, respiration, blood pressure and hemoglobin level are normal. Hemoglobin estimation and urinalysis (from catheterized specimen if necessary) should be done. Blood pressure and pulse determinations should be made every half hour. All findings should be recorded.

Treatment of Shock.—Control of pain is the first step in the control of shock. Morphine is used as necessary up to 1 grain, given in divided doses during the first hour. A proper dressing is of itself a major anodyne. Restlessness and delirium due to cerebral hyperemia may be mistaken for pain, and the excessive administration of morphine may precipitate shock and terminal crisis. Barbiturates may be used cautiously to supplement morphine, the physician bearing in mind that kidney damage slows kidney function and that in the toxic stages parenchymatous changes in the liver interfere with hepatic destruction of the barbiturate.

Shock or preventive treatment for shock should be given before dressing the burn. Intravenous electrolyte should be started first, and in all cases in which the areas given above are involved plasma should be given simultaneously. The electrolyte should consist of 10 per cent dextrose in saline solution with sodium bicarbonate, 3.75 Gm. and vitamin B complex, 2 ampules per liter.*

The first dose of plasma should be given rapidly and the first dose of electrolyte slowly unless the patient is in actual shock. If the usual peripheral veins are not accessible or are collapsed, the fluids should be given into the femoral vein, even if the groin region is burned.

It is essential to filter the plasma through sterile gauze just before using and give it through a Murphy drip set in order to observe the rate of flow. The amounts to be given are shown in table 1.

These doses may suffice for burns of 15 to 25 per cent in adults and of 8 to 15 per cent in infants who are not in shock, but in all cases of this severity or greater the systolic blood pressure and hemoglobin must be followed. If the patient goes into shock with the blood pressure below 70 mm. Hg at any time, the first dose of plasma should be repeated at once or a double dose given rapidly if none has been given. The second and subsequent hemoglobin values will indicate the need for further electrolyte and plasma in the severer cases. More electrolyte and plasma should not be given except for shock unless the hemoglobin has risen 10 points or has gone above 110 per cent, whichever is reached first. The second and all subsequent doses of electrolyte and plasma should be given as outlined in table 2. One should use 10 per cent dextrose in distilled water instead of saline solution during the remainder of the first 24 hours.

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* These ampules should contain in each ampule 10 mg. of thiamin, 4–10 mg. of riboflavin, 50–250 mg. of niacinamide, 5–10 mg. of pyridoxine and 5–50 mg. of pantothenic acid. Among the preparations meeting these standards are Betalin Complex (Lilly), Solu-B (Upjohn), and Betasynplex (Winthrop).

TABLE 1

First Dose of Electrolyte and Plasma According to Weight of Patient

WEIGHT	10% DEXTROSE ELECTROLYTE	PLASMA
lbs.	*c.c.*	*c.c.*
150 or more	1500	750
100–149	1000	500
50– 99	500	250
35– 49	250	250
20– 34	150	150
5– 19	5 per lb.	10 per lb.

TABLE 2

Subsequent Amounts of Electrolyte and Plasma to be Given for Each Point Rise in Hemoglobin or for Each Point Above 100 Per Cent According to the Weight of the Patient

WEIGHT	10% DEXTROSE ELECTROLYTE IN DISTILLED WATER	PLASMA
lbs.	*c.c.*	*c.c.*
150 or more	50	50
100–149	35	35
50– 99	20	20
35– 49	15	15
20– 34	10	10
5– 19	0.5 per lb.	0.5 per lb.

Further doses are to be given if indicated by further rises in hemoglobin. If further intravenous treatment is needed for shock after an amount of 10 per cent dextrose in distilled water has been given equal to the original dose of saline solution, only plasma should be given. Severe burns may need about 1,000 c.c. of plasma for each 10 per cent area of burn up to a maximum of 5,000 c.c. in 24 hours. Whole blood has recently been found to be at least as useful as plasma in the prevention of burn shock. When whole blood is used in large quantities, the hematocrit and hemoglobin values are unreliable indicators of blood volume.

The blood pressure determinations should be continued every half hour for 24 hours, the hemoglobin every 2 hours until stabilized, and the temperature and respiration every 2 hours. Children under 6 should have a rectal tempera~~ture reading every hour.~~

Kidney Function.—Impairment of kidney function is one of the important early complications of the severely burned patient. In order to determine the kidney function urine specimens are necessary; therefore, all patients with burns of 25 per cent or greater are put on constant drainage for the first few days. The important etiologic factors of reduced renal function appear to be shock and hemoglobinuria. Every effort must be made to prevent the occurrence of shock, or, if shock is present, to combat it vigorously and immediately. Hemoglobinuria is the result of marked hemoglobinemia, which in turn results from injury to the circulating red blood cells by heat at the time of burning. From analogy with hemolytic blood transfusion reactions, prompt and continued alkalinization of the urine during the period of hemoglobinemia (usually 48 to 72 hours) should be made. This can be accomplished initially by the intravenous injection of an ampule of sodium bicarbonate, in addition to that already recommended in the section on the treatment of shock. Later, additional bicarbonate should be given only if the urine fails to become or to remain alkaline.

Daily intake and output records should be kept for at least the first week in all patients with burns of 10 per cent or greater, and as much longer as is indicated in patients showing any impairment of renal function. An attempt should be made to keep the urine output between 1,000 and 1,500 c.c. daily. Fluids during the first day should be given as outlined previously. If thereafter the oral intake is insufficient, it should be supplemented by intravenous fluids or by clysis. No more than 1,500 c.c. of the supplemental fluids should be electrolyte. In cases with marked oliguria or anuria care should be taken not to overload the patient, particularly with sodium salts. Plasma protein, blood nonprotein nitrogen, carbon dioxide combining power and chloride, and routine urine determinations should be done frequently.

Hyperpyrexia.—Patients with burns frequently have a period of high temperature (up to 109°F.) in the first 2 days after the burn and not infrequently at much later dates. This is likelier if shock has been poorly treated but can occur without any shock. It is not necessarily the result of infection or of pyrogens in the intravenous fluids.

The patient with a burn does not tolerate a high temperature and will die if it remains at or above 105°F. for a few hours. In most cases this fever may be brought down by energetic treatment given at once. If the fluids given have not been according to the above standards, more fluid will help, but main attention should be paid to ice-water sponge baths to all exposed skin. If less than 50 per cent of the skin is exposed, it may be necessary to remove some of the dressings. Windows should be opened, a draft created, all bedclothes stripped off, an ice-water bath made in the patient's bed and the patient sponged for half an hour or more if necessary to bring the temperature down to 102°F. Heated cradles are not to be used at any time in the care of burns. Heavy blankets are to be used only temporarily during a chill or when the room is extremely cold.

Respiratory-tract Injury.—Respiratory-tract injury is a serious complication of burns. Its presence should be suspected in any patient with flame burns of the face (even minor), particularly if he gives a story of having inhaled large quantities of smoke or having lost consciousness. Consultation should be obtained immediately on such patients, particular attention being paid to the epiglottis and vocal cords. The room should be humidified, and a tracheotomy set should be kept at the patient's bedside. Respirations should be checked every half hour. If any hoarseness, dyspnea or stridor occurs, the patient should be placed in an oxygen tent. If there is evidence of bronchial spasm, aminophyllin intravenously or adrenalin or ephedrin by nebulizer should be tried. If signs of laryngeal obstruction develop, immediate tracheotomy must be done. Suction through the tracheal tube should be carried out when needed. A consultant should be on hand to perform bronchoscopic aspiration if further obstruction develops. All personnel coming in contact with the patient should be masked.

Sedation.—Restlessness may be due primarily to oxygen lack, in which case measures to increase oxygen supply as outlined above should be carried out; to pain (from surface burns), in which case demerol, rather than morphine, should be used; or to fear and nervousness, in which case barbiturates are indicated.

Chemotherapy.—Parenteral penicillin, 25,000 units intramuscularly every 3 hours, should be started on entry. If the urine output is good, sulfadiazine in full doses may also be given.

Anemia.—After the second day anemia may be troublesome. Hemoglobin determinations should be made daily until stabilization occurs, and then weekly until the patient is discharged. Whole-blood or red-blood cells in sufficient amounts are given to keep the hemoglobin at 90 per cent. Any level below 80 per cent should be corrected at once.

Nutrition.—Loss of weight, often marked, has long been recognized as a serious complication in severely burned patients. The estimation of the status of a burned patient with regard to the presence or degree of nutritional deficiency is not simple. The factors necessary for a critical evaluation are the optimum weight of the patient, the observed weight of the patient, the plasma protein level, the plasma albumin level, the plasma volume, the nitrogen intake and the nitrogen output. Actually, main reliance in clinical work has to be placed on a nutritional history, on the patient's weight, and on serum protein determinations.

The weights of these patients may be secured at each dressing change by putting the patient, covered with a sterile sheet but with the dressings removed, on a weighed stretcher each end of which is placed on a scale. Slight changes of weight are often the first indication that the patient's nutritional condition is getting better or worse.

TABLE 3

A Minimum Food Needed Daily by Patients with Burns, According to Total Area Unhealed

BURN AREA	PROTEIN	CALORIES	ASCORBIC ACID	THIAMIN	RIBO-FLAVIN	NICOTIN-AMIDE
%	*Gm.*		*Gm.*	*mg.*	*mg.*	*mg.*
20	300–400	5000	2.0	50	50	500
10–19	200	3500	1.0	25	25	200
5– 9	125	3000	0.5	15	15	100
1– 4	90	2500	0.5	10	10	50

The food provided must be an adequate metabolic mixture containing, in addition to adequate amounts of protein, sufficient calories, fat, carbohydrate, minerals, water and accessory food substances. As seen in table 3, the minimum essential needs for protein, calories and vitamins are as great as or greater than the need for these items in an illness of any kind. This table is to be followed for adults and for children weighing 50 pounds and over. The calories are reduced by 25 per cent from 30 to 49 pounds, and by 50 per cent from 15 to 29 pounds. Under 15 pounds one should give 125 per cent, 150 per cent, 200 per cent and 300 per cent, respectively, of normal proteins and calories for 1–4, 5–9, 10–10 and 20 + per cent burns. One should give 25 per cent of vitamins indicated for the area in table 3 to these infants.

Additional vitamins from liver and yeast are helpful. Severe cases should be given up to 30 Gm. of yeast a day. Liver may be given in the form of liver extract.

Whenever possible, protein losses or deficiencies should be corrected by oral feeding. It is not enough for the surgeon to order a high-protein, high-calorie, high-vitamin diet. If such a diet is ordered, the patient may fail to benefit from the order for any one of the following reasons. The diet presented to the patient is not as specified. The diet presented is not eaten in whole or in part because it lacks palatability, there is lack of appetite, and there is a lack of nurses to encourage eating. Food eaten may be partly or wholly lost because of diarrhea or vomiting.

These difficulties have been frequently encountered in caring for patients with burns during the last 2 years. The fact that the first item is mentioned may be a surprise. What especially happens in these days with the shortage of nurses is that there are frequent times when supplementary feedings are not brought to the patient because the nurse has other duties to perform that she thinks are more important or more urgent. This is particularly likely to happen at night.

The three items listed under the second item are interrelated. It is a common experience to find that a sick patient has no appetite. If, however, special attention is paid to the likes and dislikes of the patient and special or other nurses are available to encourage eating and to offer meals when the patient desires them instead of only at stated routine times, many such patients will eat a surprisingly large amount of food.

The two items under the third item are also related to each other. Forcing the diet on a sick patient does not always result in a net gain. Nausea, vomiting, distention and diarrhea, singly or together, are limiting factors. In general, the sicker the patient is the less fat is tolerated and the larger the proportion of protein should be. It has been found that at least 25 per cent of the calories in the diet should come from protein and not over 15 per cent from fat if any of these intestinal symptoms have recently occurred. It is well to take a number of days to increase the food intake, since sudden increases are likelier to be followed by gastrointestinal symptoms, which can usually be avoided by more cautious increases. If this diet is not tolerated, protein in the form of a digest should be tried and will frequently be well tolerated. The available digests are not particularly palatable and should generally be given by intubation.

Intubation feeding is important and may be used to increase greatly the intake of food. Medium-caliber nasal stomach tubes are used and left in all the time or for many hours a day. If left in continuously, the tube should be removed every third or fourth day for cleaning. About 200 c.c. of fluid may be given at a time, spaced between meals and at night, but there is a wide variation in the amount and frequency of supplementary tube feedings that different patients can take. It is well to start with a mixture of half skim milk and half water or one of protein hydrolysate and carbohydrates. Instead of supplying the mixture in intermittent doses, a drip apparatus may be used that can, after a short period of training, be regulated by some patients themselves. If 125 to 150 Gm. of protein and 2,000 to 2,500 calories are given in intubation in addition to an average house diet, the patient should receive a total of about 200 Gm. of protein and over 4,000 calories. Usually, however, the patients who are given forced supplementary feeding will not take the whole of their house diet in addition.

In certain patients needing only moderately high diets and in nearly all those needing 300 Gm. of protein or sugar, it may be impossible to furnish the required foodstuffs by the oral or gavage route. In these cases supplemental intravenous feedings are indicated. Intravenous feedings are also indicated in cases of disturbed gastrointestinal function, either primary or secondary to nutritional disturbance. In the latter cases there may be surprising improvement in gastrointestinal function after intravenous alimentation.

Parenteral feeding should be continued as a supplement until oral feeding, with or without gavage, has been established at a sufficient level not only to maintain the patient in nutritional equilibrium but also to restore at a rapid rate all tissues that have been depleted. Up to 225 Gm. of protein equivalent have been given in 24 hours in the form of an acid hydrolysate of casein (Parenamine) or an enzymatic hydrolysate and 15 per cent dextrose, which represents 50 Gm. of protein and 1,000 calories. This quantity can be given into a large vein with a 20- to 21-gauge needle in 4 hours without much danger of thrombosis of the vein and can be repeated 3 times a day. The speed of administration is limited by the amount of dextrose present, the ratio of dextrose administration not exceeding 0.8 Gm. per kilogram of body weight per hour. Administration at a faster rate produces glycosuria and excessive diuresis. Nausea may be caused if the enzymatic hydrolysate is introduced too rapidly, and thrombosis of the vein used for the injection may occur with the acid hydrolysate.

In late stages of severe burns, testosterone propionate should be given in doses of 25 mg. intramuscularly every other day to increase the positive nitrogen balance by reducing the loss of nitrogen in the urine.

POST-TRAUMATIC PSYCHOSES AND NEUROSES*

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SOME patients, following recovery from acute symptoms due to an injury, especially that of the head, appear to be unable to resume their former mode of life. They have difficulty in performing various tasks with the degree of efficiency which was usual to them before the injury.

Such patients voice many somatic complaints, particularly referable to the head; they appear emotionally dull, apathetic or depressed. They complain of inability to concentrate and difficulty in thinking, and may show varying degrees of memory impairment.

Although improvement may follow in some cases, in others the symptoms become more aggravated and abnormal mental trends appear so that some patients must be hospitalized, while others, though remaining in the community, lead a life of invalidism, being preoccupied with their somatic and psychoneurotic complaints. Frequently the disabilities present and the complaints voiced by the patient are out of proportion to the injury sustained. In some cases in which the injury appears to be relatively mild with few definite neurologic symptoms, the patient may show a greater degree of personality disturbance than following an injury of more severe degree with marked evidence of involvement of the central nervous system. Because of their apparent relationship to the trauma such personality disturbances are considered under the heading of Post-traumatic Syndrome, the benign cases being classified as Post-traumatic Psychoneuroses, the the more malignant as Post-traumatic Psychoses.

Post-traumatic Psychoses

These are usually classified as follows:

1. Traumatic delirium
2. Post-traumatic personality disorder
3. Post-traumatic mental deterioration.

Traumatic Delirium

Traumatic delirium is usually characterized by disordered sensorium, a general haziness and confusion, motor restlessness, excitement, lack of motor control, impairment of memory, loss of orientation, failure to recognize familiar persons, and fragmentary incoherent speech. Hallucinations, both auditory and visual, may be present, and the patient may show apprehensiveness and fear. Also, there may be irritability of varying degrees as well as belligerency and even assaultiveness.

A delirium following head trauma should be regarded as seriously as a skull fracture or a prolonged coma, since all three conditions may be brought about by the same pathologic processes, namely, concussion, contusion, laceration, hemorrhage, and increased intracranial pressure. The healing processes may be relatively free from pain, dizziness, unsteadiness, syncope or convulsions, yet be sufficiently extensive to alter cerebral functions as do lesions causing loss of cerebral tissue. Disturbed circulation affecting brain metabolism and nutrition may be an important factor in the recovery from head injuries.

Diagnostic and prognostic signs.—The presence or absence of skull fracture is of little prognostic or diagnostic value unless the depressed fracture causes direct mechanical compression. Severe concussions without fracture may lead as frequently to deterioration as those with skull fracture.

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Mild delirium of less than 24 hours' duration is usually followed by good recovery. Delirium of more than 1 week suggests profound damage; and determination of possible residual symptoms should not be made before the expiration of 6 months to allow for stabilization of brain tissue. Delirium or unconsciousness of more than 1 month's duration indicates severe tissue destruction and requires a guarded prognosis; 6 to 18 months may be required before an estimate of damage may be given.

The greatest damage will be apparent during the early months of convalescence before compensatory trends are fully established. Psychologic tests should be given at varying intervals before and after convalescence has set in. Age is an important factor in the prognosis. Recuperative power in the young is very good, and psychosis will seldom develop.

The presence of paranoid trends, persistence of symptoms for 2 years, and advancing age are unfavorable factors.

In some cases the delirium may persist for several weeks and resemble Korsakoff's syndrome.

Fabrications having some basis in fact, confabulations, and filling in memory gaps with imaginary occurrences given in a coherent and plausible manner may be present.

Differential diagnosis.—Organic delirium must be differentiated from hysterical symptoms in a "panic state" and hysterical delirium and from malingering. Events leading up to an accident may be so frightening that the patient, although suffering from little or no head injury, may be overcome by a panic state, with confusion, due to extreme fear. Close observation and response to therapy aid in the diagnosis. Outright malingering without hysterical components is uncommon and can usually be detected in the course of careful routine examination of the sensorium. In one way or another the malingerer will overplay or underplay his act if the physician can take enough time to permit the patient to reveal himself. Study of the prepsychotic personality is usually helpful.

A complete amnesia for events following a head injury is uncommon after the period of coma, stupor or delirium. Retrograde amnesia is more common usually for a short period before the accident, and is more diffuse and less complete than an hysterical amnesia, where there may be complete loss of identity. Loss of memory for most of the facts of the patient's life, without aphasia, is seldom due to head trauma but occurs more commonly in hysterical individuals who want to escape an undesirable life situation. Likewise, complete failure to recall the events preceding an accident occurs more frequently in persons with an hysterical personality who gain something by the amnesia, as in the case cited by Ebaugh,[1] in which a certain university student became completely amnesic after an accident in which his fiancee was killed but had his memory restored by hypnosis. It seems he was ashamed to admit that they were parked on a railroad track, and the consequent shock and guilt motivated an obliteration of a painful event.

Factors influencing recovery.—Although prolonged delirium of many weeks' duration suggests poor chances for restitution without damage, some patients make a splendid recovery because of their previously excellent integration. Of 2 men each having approximately the same type of head injury, the one with the better integration will make a better recovery. The fact that patients with apparently only a mild intellectual deterioration really have extensive cerebral damage, suggests powerful compensatory capacities.

POST-TRAUMATIC PERSONALITY CHANGE

This term is applied to patients showing fairly obvious changes in personality which are regarded as due to head injury. Some weeks or months after an accident, upon returning to his former occupation, the patient and his associates notice a lowered degree of efficiency and energy output. The patient's attention, memory and concentration power are impaired. The patient complains of headache which is usually diffuse. The headaches may be extremely painful and of long duration, and they are apt to become accentuated by mental or physical exertion, excitement or certain sensory stimuli, such as loud noises, bright lights, or heat. Tolerance for alcohol is very much lowered. Dizziness is another common symptom. Convulsions occur if the motor cortex is involved by scar formation, hemorrhage, or pressure. The patient may show periods of rage or pain. The above symptoms have no apparent relation to the presence or absence of either delirium or skull fracture. As the condition progresses the patient becomes more retarded and mentally dull; he shows little spontaneity, and his range of interests is very much narrowed. Attempts to change these reactions may cause the patient to become restless, fearful, irritable and faultfinding. Violent outbursts of rage and motor excitement of relatively short duration may be the result of efforts to stimulate the patient to greater productivity or mental effort.

Emotional shock and brain damage can result in similar personality changes, with regressive and lowered efficiency patterns. Emotional factors may and often do exaggerate the physical effects of an organic injury, and relatively mild organic disturbances may activate latent psychoneurotic trends. In many cases, therefore, it is not a question of either/or, but the factors of each must be carefully evaluated for the proper management of such cases. It is such cases which emphasize the necessity of studying them from various angles, neurologic, psychiatric and psychologic. All laboratory technics at our disposal are employed, such as pneumoencephalography, electroencephalography, specialized psychologic tests—e.g., Goldstein, Rorschach, and particularly a careful study of the prepsychotic personality, reliance being placed upon facts obtained not only from the patient and his nearest relatives but from disinterested and objective sources. The patient's work record, his social and family adjustment, and his tendency to alcoholism, his behavior under various circumstances, previous emotional experiences, and especially previous accidents, particularly head traumata, should be carefully scrutinized.

Certain criteria for the evaluation of organic damage are suggested by various authors. Kennedy[2] believes that if headache and dizziness persist for more than 4 months in a patient under 60 years of age, the condition should be regarded as of functional origin if the following 7 criteria of head injury are absent:

1. X-ray evidence of skull fracture
2. Bloody spinal fluid
3. Bleeding from skull orifices, especially the ears
4. Focal cerebral palsies
5. Convulsive states proved to be post-traumatic
6. Ventricular distortions, and
7. History of prolonged unconsciousness.

Ruesch and Bowman[3] suggest the following criteria for brain damage: convulsions, pathologic reflexes, inequality of tendon or cutaneous reflexes, cranial nerve palsies, bloody spinal fluid, disorientation and confusion.

The above criteria suggested by the quoted authors are undoubtedly of great help if they are present, but their absence does not rule out organic damage. A history of prolonged unconsciousness is of great value, but many such cases show no chronic mental or neurologic sequelae. On the other hand, clinical encephalographic and operative observations have proven that organic brain damage may be caused by head injury when unconsciousness was only of a few minutes' duration or occasionally when it was not present at all.

POST-TRAUMATIC PERSONALITY DETERIORATION

Deterioration following severe head traumata is usually manifested soon after the accident.

with or without protracted delirium, obvious skull fracture, bloody spinal fluid or increased intracranial pressure. Some apparently mild injuries are followed by gradually developing deterioration. The signs and symptoms are similar to those described under post-traumatic personality disorders, but here signs of deterioration are gross and less debatable. Retardation and lessened activity are quite obvious; attention is markedly reduced, and memory, especially for recent events, is markedly impaired. Absurd confabulations often occur. If pressed for an answer, confusion and amnesia are often the result. There is very little spontaneity. There is an inability to shift from one topic to another. Judgment defects are quite marked. Post-traumatic deterioration is not uniform in magnitude and time. The dominant personality patterns are the most persistent and last to break down. The problem becomes more complicated in the elderly who were senile or arteriosclerotic before the injury. Underlying confusion and mental impairment accompanying senility and arteriosclerosis may have been the cause of the accident.

Post-traumatic Psychoneurosis

This term should be restricted to the minor personality maladjustments, the result of head injury, and should not be applied to the psychoneuroses resulting from emotional states accompanying severe burns or frightening experiences, such as railroad accidents or shipwrecks. Such should be classified as anxiety neuroses or reactive depressions. Post-traumatic psychoneuroses following head injuries are allied to the post-concussion syndrome of Strauss and Savitsky,[4] characterized by headache, dizziness, fatigue, irritability and vasomotor disturbances.

Some individuals with a certain constitutional makeup, when exposed to unusual stress or difficult life problems, succumb to a psychoneurosis in the absence of any trauma. In post-traumatic psychoneurosis the stress remains the same but the individual's makeup is changed. Basic factors of the personality inherent in the structure of the central nervous system are changed in their various proportions so that the individual is no longer able to adjust upon the same level as formerly. Mental alertness, sense of responsibility, emotional stability and sexual desire are factors which suffer, and when they are changed they precipitate the condition known as psychoneurosis. Post-traumatic psychoneurosis is not an uncommon occurrence. The injury may be relatively minor and may or may not be accompanied by unconsciousness. The patient usually complains of headache, dizziness, nervousness, irritability, difficulty in concentration, and vasomotor disturbance. Headache is aggravated by change of position, hard work and exposure to the hot sun. Other complaints may be blurring of vision, tinnitus, fatigue, impotence and restlessness. Objectively, the patient is preoccupied, he appears dull and mentally retarded, and obviously has difficulty in concentration. The patient often realizes a change in his mental capacity and complains, "I am not the same man I used to be." Transitory confusion which readily clears up may be present.

Neurologic examination may be negative, although inequality of the pupils, ironed-out facial expression, and hyperactive deep reflexes are frequently present. Post-traumatic psychoneurosis is a relative condition varying with the severity of the injury and the individual's cortical margin.

Post-traumatic psychoneurosis, post-concussion syndrome, post-traumatic personality change, and post-traumatic mental deterioration are relative conditions, and each may gradually merge into the other. Campbell[5] states that with many of the head injuries observed as a result of war it was often difficult to estimate in the early stages whether they would become post-traumatic psychoneuroses or post-traumatic deteriorations.

Under post-traumatic psychoses I mentioned many psychoneurotic reactions such as headache, dizziness, lack of concentration power, impaired memory, and inability to carry on with accustomed work activity. Such symptoms are also frequent in neuroses when there is no question of any injury, and some writers question whether the conditions diagnosed as post-traumatic psychoneuroses have any basis in organic disturbances. Wechsler[6] suggests that in such cases we are dealing with post-traumatic encephalopathies, the pathology consisting of minute hemorrhages, glial changes, ganglion cell and fiber degeneration, atrophies and ventricular distortions. Oppenheim[7] attributes the traumatic psychoneuroses following railway or similar accidents to the physical commotion of the nervous system which causes molecular changes in the nerve tissues. Whether a psychoneurotic reaction following a relatively mild head trauma is of functional or traumatic origin could only be decided after a complete neurologic examination, various psychologic tests and a careful psychiatric study with special emphasis on the prepsychotic history being employed. When the history indicates a well adjusted individual with a good work record, good social and emotional integration, and absence of neurotic traits, a psychoneurosis following head trauma even in the absence of definite neurologic symptoms should be classified as post-traumatic. The correct diagnosis may be of importance in legal cases in which the question of compensation is involved.

Proneness to accidents deserves brief comment: The physical health is an important factor with patients sustaining injuries. Some have had brain injury before the accident, such as alcoholic or hypertensive encephalopathy and cerebral arteriosclerosis. Some have suffered previous head injuries with loss of consciousness or scalp wounds, the brain damage making them more accident-prone. The subject of accident proneness has been the object of considerable investigation. It has been shown that certain paranoid, overanxious, overconfident personalities are more prone to accidents than the average person. So, in many instances of post-traumatic psychoneurosis we are dealing with individuals who before the accident belonged to the emotionally unstable, and the traumatic experience accentuated such reactions and finally in some cases the post-traumatic situation, in which litigation and compensation problems plus worry over the future make their contribution to this psychopathologic condition.

SUMMARY

Post-traumatic psychoses and post-traumatic psychoneuroses present complexities in diagnosis and prognosis. Following a head injury, even though relatively mild, a psychosis or a psychoneurosis may develop in a normal individual with previously good adjustment and good mental and emotional stability. The absence of definite neurologic symptoms and negative laboratory findings do not rule out the organic basis for such disabilities. We owe it to our patients to supplement the above with a complete psychiatric study, a study of the prepsychotic personality, and the employment of a variety of psychologic tests which have proven of value in demonstrating disturbances of finer integration of the cerebrum and in the differentiation between organic and functional reactions.

BIBLIOGRAPHY

1. Ebaugh, F. G., and Brosin, H. W.: Symposium on scientific proof and relations of law and medicine; traumatic psychoses. Ann. Int. Med., 1943, **18**, 666.
2. Kennedy, F.: Head injuries; effects and their appraisal. Arch. Neurol. & Psychiat., 1932, **27**, 811.
3. Ruesch, J., and Bowman, K. M.: Prolonged post-traumatic syndromes following head injury. Am. J. Psychiat., 1945, **102**, 145.
4. Strauss, I., and Savitsky, N.: Head injury: neurologic and psychiatric aspects. Arch. Neurol. & Psychiat., 1934, **31**, 893.
5. Campbell, J. D.: Everyday Psychiatry: Concise, Clinical, Practical. Philadelphia: Lippincott, 1945.
6. Wechsler, I. S.: A Textbook of Clinical Neurology. Philadelphia: Saunders, 1939.
7. Oppenheim, H.: Textbook of Nervous Diseases, vol. 3. London: Foulis, 1900.

President's Page

"LET THERE BE NO DOUBT . . ."

So many months have passed since members have received any definite information about the prepayment medical plan, Medical Service of the District of Columbia, which was approved by the Society last summer, that they cannot be blamed for wondering what, if anything, is happening with regard to this undertaking. The fact is that much work has been done since its adoption. Innumerable conferences have been held by officers of the Service with officials of Group Hospitalization, Inc. for the purpose of working out details.

As our members undoubtedly know, the formal signing of an agreement between Medical Service and Group Hospitalization, whereby the latter agrees to administer the business affairs of the Service, took place on June 24. This was a "red letter day" for the new plan because Group Hospitalization has been very successful, largely because it has been efficiently administered. Competent management and the vision of its officers, particularly its President, Mr. Joseph H. Himes, have made it one of the outstanding group hospitalization plans in the country. So those responsible for the destiny of Medical Service are understandably confident that a long step has been taken to assure the Service's success.

It should be stated at this point that although Group Hospitalization administers the business affairs of Medical Service, the Service is in no danger of losing its identity. Medical Service is and will remain an independent organization. Its policies will be determined by participating physicians through their official representatives.

Now that these preliminaries have been disposed of, the next step is a most important one, that of enrolling participating physicians. Within the next few weeks a letter will go forward to all members of the Society requesting them to "sign up" for the Service. The plan, as it is now constituted, will not require the services of all physicians, but every member of the Society is requested to sign and return the contract sent him. For it is contemplated that Medical Service will eventually be expanded to include medical as well as surgical and obstetrical services. When that occurs, no additional canvass for participating physicians will be necessary.

I cannot emphasize too strongly that the response of our members will be of considerable significance to the public. Let there be no doubt in the people's minds that we are enthusiastically in favor of a plan which we are confident will do much to meet the medical needs of the citizens of Washington.

Raymond T. Holden

Editorials

THE MEDICAL SOCIETY'S RELATIONSHIP TO THE HEALTH COUNCIL*

World War II brought to the realization of the American people the startling revelation that physical unfitness had become a rule among the young men of the Nation. Since that time a great deal of study has been given to the broad matter of health. Very naturally, medical men are keenly interested in this over-all subject, for it affects their daily practice. The physician knows how vague, how inexact his patients' ideas are regarding health matters. Consequently he should be among the first to be interested in a sound educational program for the public health of the Nation.

Some time ago a study was made by a well known advertising agency as to just how interested advertisers are in the field of health. It was shown that in something over fifty per cent of the advertising in ten popular magazines of the largest circulation, all used some aspect of health as its appeal.

The physician knows too that individual knowledge and action, even when they are intelligent, are not enough. In many areas of the health field the citizens must act together. The individual is helpless when it comes to water and food protection, sanitation and waste disposal, and the control of communicable diseases. The provision of adequate hospital and clinical facilities can only be secured through community action.

These are some of the thoughts that have brought about the formation of health councils in our larger cities. Among these is the Washington Metropolitan Health Council. Its purpose is "to coördinate activities of public and private agencies; to promote coöperation among them; to prevent duplication; to eliminate waste of resources and effort; to raise health standards; to promote further community health planning, research, and education."

Here we have a million and a quarter people, living in six separate political jurisdictions, each community with its own problems and each community with many agencies seeking to meet them. But with full recognition of local authorities and local problems, we must face the fact that the metropolitan area is essentially a single economic and social unit, with many economic and social interests in common. And these interests must be served by the people of this metropolitan community through unified action.

Such community-wide action is peculiarly important in the health field, for disease flouts political and economic and social boundaries. The health of the people in Arlington and Alexandria is of concern to the people of Washington. Mortality and morbidity rates in the District affect the rates in Montgomery and Prince Georges Counties. Tuberculosis across the tracks means tuberculosis on the Avenue.

So the Metropolitan Health Council is developing as a federation of all the official and voluntary agencies of the whole metropolitan area. It has no authority or control over these agencies, but it can mobilize them for consolidated attack on common problems; it can bring about an interchange of methods and experience, it can help them in avoiding duplication and in discovering and filling unmet needs; and above all, it can contribute to the building of a real community health-consciousness. The Metropolitan Council will have full representation of local health councils and agencies through its delegate body (the membership). This body, together with the Coördinating Board or Board of Directors, which will likewise be representative of all six jurisdictions, will control the policies and activities of the central Council.

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*This is the eighteenth in a series of guest editorials by distinguished physicians and laymen.

The first step in meeting any need is, of course, to define the problem. The Council therefore, immediately upon its organization, decided upon a survey to uncover existing health facilities and their adequacy, and to determine what services must be supplied, improved, or expanded. The survey was completed, and its report was presented on April 30, 1946.

The comments and recommendations of the survey will define the official position of the Council only after a group of subcommittees have studied the various divisions of the report and have made their own recommendations, and after these recommendations have been acted upon by the Board and Delegate Body of the Council.

This study of the report is an important job. It is taking much time and infinite care, for out of the survey and the study of these committees should come a comprehensive and far-visioned health program for the metropolitan area—charter for the future activities of the Metropolitan Council and for the official and voluntary health agencies. The Council has approved the reports of three subcommittees, those on Sanitation, on Hospital Facilities and on Tuberculosis. Several other committee reports are ready for action, and other committees are at work.

Now what is the responsibility—and the opportunity—of physicians in developing and putting into effect a program adequate to meet the health needs of a great metropolitan area? Manifestly, while laymen can supply manpower, influence and funds, the medical profession, together with the dental, engineering, nursing and allied professions, must supply the technical knowledge. All committees of the Council include physicians in their membership, and this policy will undoubtedly be continued. Only with the increasing coöperation of the doctors can the job be done.

The job, it can be stated in simple terms, is to bring intelligent and adequate health service to the people of this community and to stimulate intelligent understanding and use of that service by the people. But the accomplishment of that simple program will take time, in some instances many years; and money, and this means millions of dollars; and service, and this means patience and devotion and sacrifice.

The reduction of illness, the assurance of abundant health and longer life for the people of the Washington Metropolitan Area—this is a challenge and an opportunity for all of our citizens, and particularly for the medical profession. They are capable of accepting this challenge and this opportunity, and I believe they will do it.

Ross T. McIntire, M.D.
Chairman, Washington Metropolitan Health Council

NATIONAL EMERGENCY

Probably the most important actions taken by the Atlantic City meeting of the House of Delegates were two different but not entirely unrelated resolutions having to do with possible national emergency.

The one endorsed in principle the proposed American Red Cross plan for establishment of a national blood program (see page 447 in this issue) with approval on the local level of the county medical societies. The other set up a program for National Emergency Medical Service. (The full report appears in this issue on page 450.)

The Red Cross program recognizes the need for obtaining and mobilizing blood and blood products on a local and national scale. Practically the only effective means we have for combating injuries from fission products lies in the use of blood and blood fractions. Moreover, the occurrence of local peacetime disasters of great size emphasizes the necessity for being able to mobilize quickly reserves of blood and its products.

The National Emergency Medical Service Program calls for a continuing peacetime alliance under Government auspices of the national organizations having to do with medical services for planning and quick mobilization if necessary. It calls for raising the Surgeons General to rank commensurate with and "at the level of the Chief of Staff and the Chief of Naval Operations . . . in all military and naval planning."

It recommends further the elimination of "(1) the medical overstaffing of units; (2) the wasting of the time of doctors of medicine in the performance of nonprofessional duties; (3) the removal of an excessive number of doctors of medicine from civilian hospitals and from civilian practice, and (4) a rather widespread failure to make assignments, determine rank and provide for the rotation of doctors of medicine on the basis of their professional qualifications, experience and age."

In the formulation of this program the opinion and experiences of physicians in the armed services during the past War were of great value. Questionnaires were sent by the AMA's Committee on National Emergency Medical Service to all ex-service physicians, and more than 26,000 returns were analyzed statistically by Frank Dickinson, Ph.D., appointed last year as Director of the Bureau of Medical Economic Research of the American Medical Association.

Never before has American medicine planned on such a scale for a possible national emergency. It recognizes that a future emergency could arise, and that if it does, it will require total mobilization of, and protection of, every part of our population, civil and military.

H. P. R.

DIABETES IN WASHINGTON

With the discovery of insulin twenty-five years ago by Banting and Best, the life span of the diabetic patient was increased by many years, allowing him to become a healthy individual, able to engage in the same endeavors as his fellow man.

Progress in medicine in recent years has been tremendous and perhaps the greatest strides have been made through advances in biochemistry. This is certainly true of the discovery of insulin, which has reduced the death rate in diabetic coma, enabled the diabetic to enjoy a well-balanced diet with sufficient food to sustain him comfortably, made it possible to perform successfully surgical operations without fear, and enabled the child diabetic to look to a new and ever-expanding horizon in usefulness and longevity.

For some years, physicians of Washington interested in the subject of diabetes and interested in promoting a new outlook for the diabetic patient have considered the formation of a society which would interest itself in diabetes, in the diabetic patient, and in all things helpful to the diabetic patient.

This thought nearly died a-borning. Many factors deterred this group for awhile: the absence from the city of so many physicians in military service; increased activities of those remaining with the many added civilian duties; the added hours required for student training and later postgraduate lecture work by many; and finally the usual and ever-present fear of presenting a new society to busy physicians.

These reasons, however, did not prevent a group of physicians from discussing the plan with members of the American Diabetes Association at the meeting in Toronto last September, the meeting which celebrated the 25th anniversary of the discovery of insulin. Upon their return from this meeting, these physicians soon founded The Diabetes Association of the District of Columbia, Inc. to carry forward an all-inclusive diabetic program in the Nation's capital.

There are two sub-groups of this Association: a Clinical Society and a Lay Society. The membership of the Clinical Society consists of physicians, members of allied sciences, and workers in allied fields. The membership of the Lay Society consists of diabetic patients, members of families of diabetic patients, and other laymen interested in the subject of diabetes.

The general aims of the Association are expressed in the third paragraph above. The purposes of the Clinical Society are best expressed in its By-laws, excerpts of which read as follows:

1. To furnish common ground for personal contact and free exchange of thought among physicians of the District of Columbia and its environs who are especially interested in problems of diabetes.
2. To establish constructive relationships between physicians who are specialists in diabetes, representative physicians, and allied scientists as well as members of related technical groups such as dietitians, laboratory technicians, nurses, and social workers.
3. To promote scientific understanding and conquest of problems of diabetes, especially those encountered in clinical practice.
4. To encourage adequate treatment of the disease and its various ramifications and relationships.
5. To devise and promulgate standards for diabetic clinics in the District of Columbia and its environs and to bring about the general adoption of such standards.
6. To this end to recommend to the Board of Directors of The Diabetes Association of the District of Columbia, Inc. the certification of individual hospital clinics adequately meeting prescribed standards, as well as the withdrawal of such certification on a clinic's failure to maintain the minimal prescribed standards.
7. To initiate, conduct and publish statistical surveys of diabetes on the basis of the data available.

The purpose of the Lay Society of The Diabetes Association of the District of Columbia shall be to bring together diabetic patients in an effort to further their knowledge of diabetes, to assist in developing standards of care for the diabetic patient, and to promote every possible interest of the diabetic patient. This shall be accomplished in the main through lectures by outstanding individuals in the field of diabetes and through such publicity and printed material as deemed advisable by the Board of Directors of The Diabetes Association of the District of Columbia, Inc.

The Clinical Society is now a going concern. Its membership totals over fifty; it has held its preliminary organizational meeting and is planning to present a program before members of the Medical Society of the District of Columbia, at which outstanding authorities in the field will be asked to speak. The Clinical Society feels that every physician in the Medical Society would profit by membership in this new group because, regardless of the type of practice in which he engages, sooner or later he encounters the diabetic and his problem. Further, the Clinical Society hopes to have adopted minimal standards of care for the less fortunate diabetic who attends the free clinics and outpatient departments of the many hospitals in Washington. Already some of the hospitals and their administrative staffs have shown a keen interest in the work of this group and have expressed a willingness to coöperate toward the fulfillment of the Society's aims. The Clinical Society, with the approval of the parent body, will certify to the Medical Society all who are found qualified as specialists in the management of diabetes and its complications.

The Lay Society is now being formed and the ultimate goal of membership is every diabetic patient in Metropolitan Washington. The coöperation of the attending physician is absolutely needed for the accomplishment of this goal. By organizing a lay group, the diabetic patient will be given an added incentive for achieving good health habits.

The medical profession then is again pioneering in a new method of care and treatment of patients. The diabetic patient is assured of accurate and specific application of approved principles of treatment. This new group will provide the physician with information concerning the treatment of diabetic patients through experts in the clinical field of diabetes and with latest data on all research work through investigators in this field. In chronic diseases only too often the physician's activities are limited to palliative management, symptomatic treatment, and terminal comfort for his patient, but in diabetes, though considered chronic and without cure, today is offered mathematically precise treatment which leads to longevity greater than average and good health through aging years.

Thus once again through the vigilance of the medical profession of Washington in bringing the best in medical care to their patients in a progressive and interesting fashion, the Nation's capital moves toward becoming a world medical center.

John A. Reed, M.D.
Maurice Protas, M.D.

METOPON HYDROCHLORIDE

(Methyldihydromorphinone hydrochloride)

In 1929 with the funds provided by the Rockefeller Foundation the National Research Council, through its Committee on Drug Addiction, undertook a coördinated program to study drug addiction and search for a non-addicting analgesic comparable to morphine. The principal participating organizations were the Universities of Virginia and Michigan, the United States Public Health Service, the Treasury Department's Bureau of Narocotics, and the Health Department of the State of Massachusetts, which brought together chemical, pharmacologic and clinical facilities for the purposes of the study. Metopon is one of the many compounds made and studied in this coördinated effort.

Chemically metopon is a morphine derivative; pharmacologically it is qualitatively like morphine even to the properties of tolerance and addiction liability. Chemically metopon differs from morphine in three particulars: one double bond of the phenanthrene nucleus has been reduced by hydrogenation; the alcoholic hydroxyl has been replaced by oxygen; and a new substituent, a methyl group, has been attached to the phenanthrene nucleus. Studies made thus far indicate that pharmacologically metopon differs from morphine quantitatively in all of its important actions: Its analgesic effectiveness is at least double and its duration of action is about equal to that of morphine; it is nearly devoid of emetic action; tolerance to it appears to develop more slowly and to disappear more quickly and physical dependence builds up more slowly than with morphine; therapeutic analgesic doses produce little or no respiratory depression and much less mental dullness than does morphine; and it is relatively highly effective by oral administration.

In addition to animal experiments these differences have been established by extensive employment of the drug in two types of patients, individuals addicted to morphine, and others (terminal malignancies) needing prolonged pain relief but without previous opiate experience. In morphine addicts metopon appears only partially to prevent the impending signs of physical and psychic dependence. In terminal malignancy, administered orally it gives adequate pain relief, with very little mental dulling, without nausea or vomiting, and with slow development of tolerance and dependence.

The high analgesic effectiveness of oral doses (with the elimination of the disadvantage to the patient of hypodermic injection), the absence of nausea and vomiting even in patients who vomit with morphine or other derivatives, the absence of mental dullness, and the slow development of tolerance and dependence place metopon in a class by itself for the treatment of the chronic suffering of patients with malignant neoplasms, and it is for that purpose exclusively that it is being manufactured and marketed.

Metopon will be available only in capsule form for oral administration. The capsules will be put up in bottles of 100, and each capsule will contain 3.0 mg. of metopon hydrochloride. They can be obtained by physicians only from Sharp & Dohme or Parke, Davis & Company on a regular official Narcotics Order Form, which must be accompanied by a signed statement supplying information as to the number of patients to be treated and the diagnosis on each. The drug will be distributed for no other purpose than oral administration for chronic pain relief in cancer cases.

The dose of metopon hydrochloride is 6 to 9 mg. (2 or 3 capsules), to be repeated only on recurrence of pain, regular by-the-clock administration being avoided. As with morphine, it is most desirable to keep the dose at the lowest level compatible with adequate relief of pain. Therefore, administration should be started with 2 capsules per dose, increasing to 3 only if the analgesic effect is insufficient.

Tolerance to any narcotic drug develops more rapidly with excessive dosage and under regular by-the-clock administration. Also, as a rule, the pain of cancer varies widely in intensity from time to time. Pain, therefore, should be the only guide to time of administration and dosage level. Tolerance to metopon hydrochloride develops slowly. It can be delayed or interrupted entirely by withholding the drug occasionally for 12 hours or for as much of that period as the incidence of pain will permit.

To each physician will be sent a record card for each patient to whom metopon hydrochloride is to be administered. He will be requested to fill out these cards and return them in the addressed return envelope. He must furnish this record of his patient and his use of metopon hydrochloride if he wishes to repeat his order for the drug. The principal object of this detailed report is to check the satisfactoriness of metopon hydrochloride administration in general practice. The physician's coöperation in making it as complete as possible is earnestly solicited.

* * *

The limited use of metopon hydrochloride as described above has been recommended by the Drug Addiction Committee of the National Research Council, and the Committee with the coöperation of the American Cancer Society will supervise the distribution of the drug. The Committee is composed of Wm. Charles White, *Chairman*, Washington, D. C.; H. J. Anslinger, Commissioner of Narcotics, United States Treasury Department, Washington, D. C.; Lyndon F. Small, National Institute of Health, Washington, D. C.; and Nathan B. Eddy, National Institute of Health, Washington, D. C. Queries and comments on metopon may be directed to Dr. Eddy, who will answer them for the Committee.

REFERENCES

1. Small, L., Fitch, H. M., and Smith, W. E.: Addition of organomagnesium halides to pseudocodeine types; preparation of nuclear alkylated morphine derivatives. J. Am. Chem. Soc., 1936, **58**, 1457.
2. Small, L., Turnbull, S. G., and Fitch, H. M.: Addition of organomagnesium halides to pseudocodeine types; nuclear-substituted morphine derivatives. J. Org. Chem., 1938, **3**, 204.
3. Small, L., and Fitch, H. M.: U. S. Patent 2,178,010, October 31, 1939.
4. Eddy, N. B.: Search for more effective morphine-like alkaloids. Am. J. M. Sc., 1939, **197**, 464.

(Continued on page 467)

The Editors' Forum

LOOK—SEE!

Dwight L. Wilbur, M.D.

Editor, California Medicine

Editor's Note: A comparative newcomer to the ranks of state medical journal editors, Dr. Wilbur has already demonstrated his ability. At a meeting of editors held in Chicago last December, Dr. Morris Fishbein observed that *California Medicine,* under Dr. Wilbur's editorship, had made remarkable progress, a statement in which his fellow editors will heartily concur.

Dr. Wilbur is the son of Dr. Ray Lyman Wilbur, to whom reference is made in the following article.

A good many years ago, my father, who was then a practicing physician arriving home from a year of study in Europe, was met at the train as he alighted in Palo Alto by Louie, the most prominent cook on the Stanford Campus and the head of the local Chinese tong.

"Doctor," said Louie, "you come see my wife? She sick!"

My father called to Louie's attention the fact that he had been away for over a year and had not even had a chance to stop at home. He suggested that some other physician be asked to see the sick woman. Louie answered promptly by informing my father that this already had been done when he said, "Other doctor come, look. You come, look—see."

This classification of doctors into those who "look" and those who "look—see" is as sharp today as it was forty-three years ago when the above noted incident occurred. It might well make us pause for a few moments and reflect on certain phases of the practice of medicine and, in fact, on some of the problems which medicine faces in the field of economics.

The practice of medicine is at once a science and an art. Until the latter part of the nineteenth century it was largely an art. Since then, scientific and experimental medicine have risen rapidly and today the practice of medicine is, in many important respects, a science. Much of the art of medicine of today has to do not only with the management of diseases about which very little is known but also with the proper application of what is known scientifically about a disease in the care of a patient.

The diagnosis of leukemia, of diabetes and of many forms of cancer, for example, has been reduced almost to a scientific formula in which the only prerequisites to diagnosis are the ability of the physician to think of the possibility of the disease and to have available proper facilities to establish the formula. On the other hand, in the diagnosis of hysteria, nervous indigestion, and in the recognition of the early stages of many, if not most, chronic diseases, the art of medicine predominates. For the physician who is most skillful in asking the right questions, in discovering the presence of certain fine points in physical examination, in noting the response of the patient to himself and his environment, in accurately interpreting laboratory data of uncertain value and, above all, in correlating all he has learned about the patient with his own experience, will be using, at its best, the art of medicine as the principal element in establishing a diagnosis.

Similarly in the prevention of an epidemic of diphtheria or in the successful treatment of pneumococcic pneumonia or pernicious anemia, the science of medicine predominates; and in the attainment of the eventual result, provided certain established requirements are met, it makes very little difference who practices the scientific medicine or how much or how little of the art of medicine is included. However, in the successful management of a patient with an anxiety state or irritable colon or an uncomplicated duodenal ulcer or menopausal symptoms, the science of medicine, while helpful, is useful principally in how it is applied by the physician.

Most medical students, house officers, and young physicians still are being trained almost exclusively in the science of medicine and very little in the art of it. Their principal thoughts about a patient are apt to center about laboratory tests, roentgenologic examinations, and biopsy reports. These methods of diagnosis are scientific but they are expensive and they are often hopelessly overdone in cases of minor and occasionally of major illnesses. These "machine methods" require much expensive equipment and the aid of expert physicians and technicians. They are contributing in an alarming extent to the present trend in which hospitals and not physicians are taking the lead in the practice of medicine and to the high costs of good medical care. They are in my mind in large part the "look" of medicine. They have to do principally with the problem of a disease and the treatment of it.

On the other hand, much of medicine is still unknown and not scientific in the strict sense of the word. In the practice of his profession, the wise and successful physician must not only "look" with the science of his profession, and observe and treat a disease, but he must also "see" the problem of the patient, apply only what is needed of the science of medicine and, more frequently than not, make his diagnosis and base his treatment on opinion and speculations based on experience. In the successful diagnosis and management of a patient with coronary heart disease and angina pectoris, or hypertension or a psychoneurosis or numerous degenerative diseases, the physician who is skillful in the art of medicine will not only know where and how much to "look" but above all, he will know how to "see" and therefore how best to apply what he knows to the successful management of his patient.

The art of medicine grows with experience in one with certain native abilities. It should be given more consideration in the training of the young physician. While he will find great satisfaction in practicing the science of medicine, the physician actually will get his greatest pleasure and happiness in practicing its art. It is his skill in practicing the art of medicine which makes a physician stand out among his fellows.

Look—See!

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Two sessions of the House of Delegates, American Medical Association, were held daily in Atlantic City, New Jersey, June 9 to 12, inclusive, except June 11 (one session). The two delegates from the District of Columbia attended all sessions. A total of 173 out of 175 delegates were registered.

Distinguished Service Award:—This award by ballot of the delegates went to Dr. Henry A. Christian of Brookline, Mass., for outstanding accomplishment in medicine.

Address of President:—President Harrison H. Shoulders delivered an able address which was highighted by a vivid illustration of the parallel between scientific attainment in medicine and cost of medical lservice. One paragraph is quoted in full:

> "When appendicitis was treated largely by the administration of opium pills and the application of poultices to the abdomen, the cost of administering such treatment was low but the resulting mortality was high. When the physician acquired an understanding of the disease and perfected a technic for its proper treatment, the mortality from the disease went down to a low level but the cost of treatment went up. When diabetes was treated largely by diet and the administration of codeine, the cost of such treatment was low but the mortality was high. The diabetic patient lingered in discomfort for a relatively short while. But when the members of the profession acquired an understanding of the disease and developed a specific method for its treatment and management, diabetic patients were given an almost normal life expectancy in comfort and usefulness. Thus the problems in medical economics have been brought to the forefront."

Address of President-elect:—In the address of President-elect E. L. Bortz recommendations were made, which later in the week were adopted, having to do with the conduct of the annual Interim (December) Meeting of the House of Delegates. Important changes are noted as follows: the meeting will be held in various sections of the country rather than continuing in Chicago; a two-day scientific session with program designed especially for general practitioners will precede the meeting of the House of Delegates.

Letter from preceding President-elect:—A communication from Dr. Olin West was read in which he expressed regret at being unable to be present. Through his retirement, due to illness, Vice President Bortz had become President-elect. It was voted to give Dr. West the President's Medal in recognition of his services.

General Practice:—The alleged exclusion of general practitioners from the staffs of certain hospitals was dealt with in a report of the Council on Medical Education and Hospitals, which quoted a resolution passed by the House of Delegates at San Francisco in 1946 as follows:

> "WHEREAS, Many hospitals have not established general practice sections in their visiting active staffs, and their governing heads are doubtful whether such action has the approval of the bodies which set up the rules and regulations for the approval of their hospitals for interns and residents; therefore be it
>
> RESOLVED, that hospitals should be encouraged to establish general practitioner services. Appointments to a general practice section shall be made by the hospital authorities on the merits and training of the physician. Such a general practice section shall not per se prevent approval of a hospital for the training of interns and for residencies. The criterion of whether a physician may be a member of a hospital staff should not be dependent on certification by the various specialty boards or membership in special societies."

It also quoted a report it had published in the *Journal of the American Medical Association*, May 3, 1947, page 95, as follows:

> "At the direction of the House of Delegates of the American Medical Association some years ago, the Council on Medical Education and Hospitals formulated standards for the establishment of American boards for the certification of specialists and for the conduct of hospital residencies providing training in the various special fields of medicine. The aim was to improve the quality of training at this level of medical education. The physician responsible for directing such hospital training should himself have had training and experience approximately equivalent to that required of certification applicants, whether or not he is actually certified. But it was never intended that staff appointments in hospitals generally, or even in hospitals approved for residencies, should be limited to board certified physicians. as is now the policy in some hospitals. Such policies, if practiced extensively, are detrimental to the health of the people and therefore to American medicine. Hospital staff appointments should depend on the qualifications of physicians to render proper care to hospitalized patients as judged by the professional staff of the hospital and not on certification or special society memberships.
>
> "In this opinion the Council has the full concurrence of the Advisory Board for Medical Specialties, which represents all of the American boards in the specialties. At the February 1947 meetings of the Advisory Board it was unanimously voted to adopt as the sentiment and policy of the Advisory Board the recent resolution passed by the American Board of Surgery, which reads:
>
> "The American Board of Surgery is not concerned with measures that might gain special privileges of recognition for its certificants in the practice of surgery. It is neither the intent nor has it been the purpose of the Board of Surgery to define requirements for membership on the staffs of hospitals. The prime object of the Board is to pass judgment on the education and training of broadly competent and responsible surgeons—not who shall or shall not perform surgical operations. The Board specifically disclaims interest in or recognition of differential emoluments that may be based on certification.'
>
> "Since February, several separate American boards in the various specialties have taken similar action. The Council on Medical Education and Hospitals of the American Medical Association is completely in accord with this principle."

At this meeting the House approved a change in section 3, paragraph 6 of the "Essentials of a Registered Hospital," to read as follows: "6. Staff sections, such as medicine, obstetrics, surgery, *general practice*, etc., should be organized as may seem wise." This action gives encouragement and endorsement to the establishment of general practice sections in approved hospitals.

United Mine Workers Health and Hospital Fund:—Congratulating Rear Admiral Joel T. Boone and his teams on their recent survey of health in the bituminous mine industry, the House recommended joint conferences directed toward improved health in the mines, between the Unions, mine operators' associations, the American Medical Association, Association of Coal Mine Physicians, American Hospital Association, American Dental Association, and the American Nurses' Association.

Veterans' Home Town Medical Care Program:—With reference to the enlarging of the full-time clinic facilities of the Veterans Administration the House adopted a report which stated that "new factors have arisen that have resulted in the Veterans Administration altering its policy" and recommending and authorizing a conference between the Council on Medical Service, the Board of Trustees, representatives selected by state medical societies and the Veterans Administration "to effect solution of any existing problems."

Revision of Constitution and By-laws:—Drafts of proposed changes in the Constitution and By-laws of the American Medical Association were delivered to delegates for action one year hence.

Section on Diseases of the Chest:—A new Section on Diseases of the Chest was recommended to be established in the American Medical Association at the next annual meeting. An active promoter of this development was Dr. J. W. Peabody of the Medical Society of the District of Columbia.

Washington Office:—The House adopted a resolution giving "great praise" to Dr. Joseph S. Lawrence and the Washington staff for their work.

Health Problems of the Secretary of the Interior:—A resolution was adopted endorsing an arrangement by which Secretary Krug has appointed a committee from the Board of Trustees, the Secretary and General Manager, the Editor of the *Journal of the AMA*, and Dr. William A. Morgan of our Society, to select teams of physicians to go on expeditions to give medical service to the wards of the Department of the Interior in outlying areas of United States possessions.

National Emergency Medical Service and the American Red Cross Blood Bank Program:—The House approved in principle the American Red Cross Blood Bank Program.* It also adopted a report on National Emergency Medical Service† which seeks to eliminate administrative and other faults of previous wars and to organize a group of national professional societies for any emergency which might arise. This report should be read in detail as its implications and importance are far-reaching.

Many other very important actions were taken by the House and the members of this Society should read in detail the minutes of the House of Delegates.‡

The House elected officers before adjournment as follows:

President-elect: Roscoe L. Sensenich, South Bend, Indiana

Vice President: Thomas A. McGoldrick, Brooklyn, New York

Secretary: George F. Lull, Chicago, Illinois

Treasurer: Josiah J. Moore, Chicago, Illinois

Speaker of the House of Delegates: R. W. Fouts, Omaha, Nebraska

Vice Speaker of the House of Delegates: F. F. Borzell, Philadelphia, Pennsylvania

Trustees: Dwight H. Murray, Napa, California and E. J. McCormick, Toledo, Ohio. (Seven other trustees continue in office.)

Respectfully submitted,
Coursen B. Conklin, M. D.
Herbert P. Ramsey, M. D.
Delegates

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* See following article.

† Published in full in this issue of the Annals, pp. 450–1.

‡ J. A. M. A., vol. 134, nos. 8, 9 and 10, June 21, 28, and July 5, 1947.

NATIONAL BLOOD PROGRAM OF AMERICAN NATIONAL RED CROSS

The great values of blood transfusions in the saving of lives have long been known. Transfusions were given to a limited extent in World War I for combating hemorrhage and shock in the American Expeditionary Forces. The knowledge of the uses of blood then available was by no means comparable to that which exists today about the miracle of blood.

Between the World Wars a number of notable contributions were made by medical research. Methods of collection, preservation and administration were improved. New properties of blood were discovered. Their usefulness in a wide variety of diseases became revealed. Discovery that plasma could be dried to a powder and dissolved in water when needed, was in itself a great advance because of the ease with which it could be stored, transported and used in emergencies wherever they might occur.

In World War II our Government called upon the American Red Cross as the logical agency to procure the blood that proved to be one of the foremost lifesavers of the War. No greater opportunity was ever afforded than that of supplying the needed, badly needed, blood. This wartime program was a spectacular success. A great factor in its success was the spirit engendered by the Red Cross in the hearts and minds of the people of this country—a spirit that moved them to give freely of themselves so that the sick and wounded of their Armed Forces might survive. Thousands live today because of the people everywhere who responded to the Red Cross appeal for blood.

Any beneficial knowledge that can be gained from war should be turned to the aid of a war-surfeited people in time of peace. Based on the experience of World War II the use of blood in the treatment of sick and wounded people has become standard procedure throughout the world. Nor is the current knowledge of blood by any means complete. Some of the greatest physicians and scientists of our time are devoting themselves to the study of blood and its uses. There is promise that further revolutionary discoveries will be made if sufficient amounts of blood can be provided for continued widespread use and observation combined with intensive research.

In 1946 more than 2,000,000 pints of plasma were declared surplus to the needs of the military. They were returned to the Red Cross for free distribution through state health departments for civilian use. It is estimated that this surplus plasma will supply such needs for perhaps another year. Replenishment must be provided, and very soon, lest many of our people die from lack of plasma.

The need for whole blood is also acute. It will become increasingly so as more physicians become skilled in recognizing the indications for its use and more facilities for its administration become available. Likewise more derivatives of blood are being developed and used as life-saving aids to increasing numbers of people for injuries, surgical operations, and the treatment and prevention of disease.

It is of vital importance that action be taken at once to make further study of blood possible and to supply the constantly increasing needs for it and its products. If such action is to be effected, one person in every thirty-five will have to give blood at least once each year to supply the needs of our country, or 3,700,000 contributors annually. Any healthy person in the United States may be a giver. Anyone in need of it may be a receiver of the miraculous powers of blood. Many will be both.

The source of blood is confined to the veins of the people. It cannot be compounded nor manufactured as are biologic products, medical supplies and drugs. Blood cannot be purchased commercially and supplied in the various forms to meet the needs without costs that are beyond the resources of the vast majority of our people. Governments have not been able to compel the contribution of blood from their citizens. Even the totalitarian nations were dependent upon voluntary contributions to meet their needs during the War. The operation of blood banks by private and community hospitals is limited in application and cannot be expected to meet the national needs. It is only by the procurement and distribution of blood on a large scale that costs can be lowered and the quantities necessary be provided.

How could sufficient blood be obtained to meet the needs of the American people for whole blood and blood derivatives? Could the Red Cross with its wealth of experience in reaching millions of people and with its specific experience in blood donor work undertake this program as a peacetime service? Was it a Red Cross job? Could Red Cross chapters collect enough funds to carry out a program of such magnitude?

The Central Committee, though receptive to the suggestion that the Red Cross undertake this responsibility, wanted these questions taken to the Red Cross chapters for consideration. The Central Committee felt that the opinion of the chapters was most important. After all, their role would be a major one should such a program be undertaken. Accordingly, 18 regional meetings were held. The discussions at them indicated that 97 per cent of the representatives of the 714 chapters in attendance recognized the need for the American National Red Cross to undertake a National Blood Program.

Prior to further action, the proposed program was discussed with and approved in principle by such agencies as the American Medical Association, the Association of State and Territorial Health Officers, the American Public Health Association, the United States Public Health Service, the U. S. Veterans Administration, the Army, the Navy, and the American Hospital Association.

On June 12, 1947, the new Board of Governors, American National Red Cross, meeting in Cleveland, Ohio, ratified and confirmed a previous action of the Central Committee approving and authorizing the National Blood Program as an activity of the American National Red Cross. By this decision they brought to a climax several years of intensive study and consideration of what the American National Red Cross might do to help supply blood needed to safeguard the health of all the people of the Nation and to be the means of saving the lives of untold thousands.

This action insures to peacetime the gains to humanity of the record in life-saving that had never been equaled before in times of war. It recognizes that the lessons learned since the dropping of the atomic bombs on Hiroshima and Nagasaki call for broad national planning to meet the future needs of national defense, both military and civilian.

There are five important operations in connection with a national blood program: (1) collecting the blood; (2) processing it for use as whole blood and blood derivatives, including packing and storage; (3) distributing the blood and blood products for the needs of the people; (4) making blood available for continuous research and investigation to insure safety of the products and to determine the uses to which they may be put for the greatest benefits of mankind; and (5) maintaining of high standards set by the leading authorities in this field.

A program of such magnitude must of necessity be one of gradual development. Time will be required to organize the work, to procure and train the personnel, and to obtain equipment which is in short supply. The first year of operation contemplates the establishment of 20 or 25 centers carefully selected with relation to the advantages they offer in the early stages. It is estimated that from three to five years will be required before the program is in full operation. In the meantime local programs will continue on their present basis, and new programs will be established as heretofore with the expectation of integration with the national program later on. In this way, full benefits from the fractionation phase of the program will be available to those communities where only whole blood and plasma are now being provided.

In addition to whole blood and plasma, the National Blood Program will provide other blood derivatives of proved value: serum albumin, used for shock and certain kidney diseases and other conditions; immune serum globulin, for modification or prevention of measles; antihemophilic globulin, effective in the treatment of hemophiliacs, or "bleeders"; blood grouping serum, for determining blood types; fibrin films, used in brain and nerve surgery; red cell suspensions, for treating certain anemic conditions; and red cell paste and powder, to promote the healing of certain wounds. Any other products which continuing research may find useful in medicine and surgery will be provided.

Since people in rural districts require blood as well as those in cities the program must be sufficiently flexible to meet widely varying conditions and needs in large and small communities throughout the country. It is the ultimate goal to collect blood from volunteers from every community everywhere and to give every healthy person an opportunity to make a contribution at least once a year. For those people to whom a blood donor center is not available it is planned to provide the services of a mobile unit.

Under certain conditions it may be expedient to type the donors in a community and have them available when whole blood is needed in an emergency situation. In other instances plasma or serum albumin and other stable derivatives will be made available and will tide cases over until whole blood can be transported from a central depot where all types are constantly on hand. In this way the program will be enabled to fulfill its purpose to furnish blood, blood plasma, and all of its derivatives to all the people of this country irrespective of race, creed, color or financial ability to pay. The only charge ever made to any patient will be a reasonable one by the physician or hospital for professional services in administering the material. The Red Cross will make no charge.

That part of the program which deals with collecting blood will operate substantially along the same lines as the wartime blood program, with established blood donor centers, and with mobile units to cover outlying communities. Red Cross chapters will assume the important responsibility of complete community organization to enroll blood donors and will arrange for the bleedings as needs require. In addition to the competent professional personnel for technical work, many volunteers will be necessary for nontechnical work in the centers.

That part of the program which deals with processing of the blood will involve highly skilled work. Some of the blood collected will be examined, typed, and distributed to local hospitals for use as whole blood; some of it will be shipped to commercial laboratories with which contracts will be made by national headquarters to fractionate blood into its derivatives. It is believed that approximately 60 per cent of the blood collected will be used as whole blood.

That part of the program which deals with distribution involves making the best possible arrangements that will afford ready accessibility of the blood and blood products to all people and their physicians and hospitals, including veterans, military, and marine as well as civilian hospitals.

That part of the program which deals with continuous research and study as to the effectiveness and new uses of the blood products will be carried on by research authorities with the guidance of the Blood and Blood Derivatives Committee of the American National Red Cross Advisory Board on Health Services.

Inasmuch as, on the basis of recorded scientific and medical opinion, there is no difference in the blood of humans based upon race or color, the plan does not require the segregation of blood; however, whenever necessary to insure the success of the plan, which is to make available blood and blood derivatives to all the people of the United States regardless of race or color, chapters will collect and hold blood in such a manner as to give the physician and the patients the right of selection at the time of administration.

Operating centers of the National Blood Program will be selected and established only after full consultation between the national organization and the chapters concerned. Such chapters will be furnished with complete and detailed information covering the method of organization of the chapter blood donor service, ground work for community support, public relations and promotion, the use of publicity, suggested publicity aids, the operation of the blood donor center, clinic instructions, and the relationships between chapters, area, and national headquarters.

The program will be financed through contributions made by the American people. Each year the Red Cross fund campaign will take into consideration the amount necessary to carry on this important new service.

The cost for the first year may be between three million and five million dollars. The costs of operation of the centers will be shared on an equitable basis between the national organization and the chapters.

The value received from the cost of the program cannot be estimated, for there is no way to determine the value of lives saved by having blood and blood products available when needed. One can rely, however, on the testimony of the medical profession as to what has already been accomplished and on the statement of the most eminent scientists in the blood field that we are on the brink of even greater discoveries in the uses of blood for the benefit of mankind.

REPORT OF REFERENCE COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE*

Your reference committee has reviewed in detail the report of the Committee on National Emergency Medical Service. It desires to commend the Committee for the diligence with which it has pursued the tasks assigned it by the Board of Trustees at the direction of the House of Delegates.

1. Your reference committee is greatly impressed by the Committee's recommendation for the very urgent need for continuous national planning for emergencies, especially in the fields of medical service, health, sanitation and emergency mobilization as well as the necessity of continuous alert supervision of all developments in these fields. In the opinion of your reference committee the possibility of the new aspects of total warfare and special weapons requires that the developments and planning for medical care be continuous. It is, furthermore, the opinion of your reference committee that this is a major project before your House of Delegates and that it warrants continuing investigation, study and most careful consideration and planning.

2. Your reference committee concurs in the following recommendations of the Committee on National Emergency Medical Service and recommends their adoption:

(a) The President of the United States of America and the Congress should be respectfully urged:

(1) That in war and in peace the Surgeons General of the armed forces have the authority and responsibility for participa-

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* Adopted as amended by the House of Delegates of the American Medical Association at the annual session in Atlantic City, N. J., June 9–13, 1947. The amended report, published herewith, is reprinted from J. A. M. A,. 1947, **134**, 884.

tion, with commensurate rank and at the level of the Chief of Staff and the Chief of Naval Operations of the armed forces, in all military and naval planning, organization and operations as these relate to medical, health, sanitary and welfare services and for the assignment and utilization of medical and allied personnel at home and abroad.

(b) That the Secretary of War and the Secretary of the Navy and such other cabinet officers as may be charged with responsibility for our national defense give consideration to possible civilian requirements in a total war in the planning, location and construction of military hospitals and that they reëxamine their organizational tables and other procedures used during World War II in order to avoid (1) the medical overstaffing of units; (2) the wasting of the time of doctors of medicine in the performance of nonprofessional duties; (3) the removal of an excessive number of doctors of medicine from civilian hospitals and from civilian practice; and (4) a rather widespread failure to make assignments, determine rank and provide for the rotation of doctors of medicine on the basis of their professional qualifications, experience and age.

(c) The American Medical Association should go on record as favoring the creation of a National Emergency Medical Service Administration as a continuing function of Government, such Administration to consist of representatives of the Advisory Board for Medical Specialties, American College of Physicians, American College of Surgeons, American Dental Association, American Hospital Association, Catholic Hospital Association, Protestant Hospital Association, American Medical Association, American Nurses' Association, American Pharmaceutical Association, American Public Health Association, American Veterinary Medical Association and Association of American Medical Colleges.

3. National Emergency Medical Service Administration: This Administration shall be charged with the responsibility at all times (1) for effecting plans for total mobilization of the medical and allied resources of the Nation; (2) for the procurement and allotment of medical and allied personnel in case of a national emergency; (3) for the coördination of civil and military medical and allied services in times of threatened or actual national emergency, provided that in the exercise of this function there shall be added to the Administration the following members: the Surgeon General, U. S. Army; the Surgeon General, U. S. Navy; the Surgeon General, U. S. Public Health Service; the Air Surgeon; the Medical Director, Veterans Administration; a representative of the National Research Council; and a representative of the American Red Cross.

4. Creation of Council on National Emergency Medical Service: In reference to that part of the report that pertains to the continuous study of this very important assignment, your reference committee concurs in the recommendations of your Committee on National Emergency Medical Service and recommends that this House of Delegates authorize the Board of Trustees of the American Medical Association to create and appoint a standing committee to be designated as the Council on National Emergency Medical Service.

5. Commendation of Work of Committee: Your reference committee commends the Committee on National Emergency Medical Service for the very exhaustive investigation and study which has resulted in this timely, efficient and epochal conclusive report. It recommends that the House of Delegates extend a vote of thanks to the members of this Committee.

Respectfully submitted,
CHARLES H. PHIFER, *Chairman*
HERBERT P. RAMSEY
JAMES R. MCVAY
FRANK L. COLE
MORTON D. WILLCUTTS
THOMAS A. FOSTER
GEORGE P. JOHNSTON

WHAT A CITY EDITOR LOOKS FOR IN A NEWS RELEASE*

I. William Hill

City Editor, Washington Evening Star

Editor's Note: Although the following address was prepared especially for executives of medical organizations, it should provide interesting and enlightening reading for physicians. There is much discussion among physicians as to how their relations with the public can be improved. Mr. Hill directs his attention to methods of improving relations between the medical profession and the press.

What does a city editor look for in a news release? That's easy to answer. He's looking for something he very rarely finds. He's looking for something apparently as remote from news releases as was an honest man from the gleam of Diogenes' lamp. What does a city editor look for in a news release? He looks for news. He doesn't even ask for the whole story, just a germ, just an infinitesimal tip. You'd be surprised, I think, how rarely he finds it.

Let me sketch a picture for you. It's early in the morning in the news room of the *Evening Star* in Washington. From every conceivable source he can think of, the city editor is trying to gather whatever material will be of information and interest to the readers of the paper that afternoon. He has reporters assigned to police, courts, the Capitol, the White House, the Medical Society—every place where news can be anticipated.

At that moment, the city editor's secretary gets the morning mail open and puts before the city editor a stack of papers three or four inches high. It's always a little staggering for, believe me, the city editor would have plenty to do that morning if there were no mail at all. Nevertheless, each news release there has to be looked at. You never know which piece of paper may contain information that will lead to a page one story. But wait. What does the city editor find?

Here's a news release about a new plastic beer bottle and the second concerns a gadget (on sale at the corner drug store) that you can put in your mouth, breathe in and relieve your cold. No news yet. Just advertising. Now we get down to a news release detailing why rent control should be abolished. It doesn't even represent the action of any organization to that effect. And what's this? A news release, written in German, the only distinguishable fact being that it's on the subject of housing. These are propaganda. No news yet. Here are a couple of Government handouts, lovely news releases prepared, one can't help but guess, merely because the author was on the payroll and had to write something that day to justify his desk space. Can you imagine a reader in Washington wanting statistics on sheep-dipping in a western state? No news yet. And so on and so on, through an average of 150 news releases in the morning mail.

From these the city editor culls 20 or 25 to be rewritten by reporters into short items. These will include announcements of meetings, dinners, coming conventions, etc., a type of material many papers don't use because its actual news value is debatable. Then there are releases that are a matter of record. The Medical Society has gone on record in favor of a certain piece of pending legislation, or some trade union has come out in opposition to the labor control bill. These matters are news. Yes, but news of an expected, and therefore routine variety. None of them contains that precious spark of surprise, that exciting hint of the unexpected that the city editor is always seeking. I say none. Occasionally there will be one or two, enough to make it necessary to plunge in on tomorrow's stack of news releases.

Perhaps I'm bitter. Undoubtedly more news releases are prepared in Washington than in any city in the world. No doubt they are better prepared in Washington than in most cities. They ought to be. Their authors have more practice. Please remember that, in addition to the 150 news releases that found their way to the city editor's desk, there are the uncounted scores that are given Washington reporters covering the various Government departments. Nevertheless, by far the great majority of these news releases find their way, not into print, but into the bottom of a wastebasket.

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* Delivered at the first annual meeting of the Medical Society Executives Conference at Atlantic City, June 11, 1947. The Conference is an association of executive employees of national, state and regional, and county medical societies devoted to the mutual improvement of its members in discharging their administrative functions. Theodore Wiprud, Secretary of the District Medical Society, was the first Chairman of the Conference.

Before I get away from being bitter, let me supply you with some statistical justification for it. These statistics were gotten together by Mr. Neil McNeil, Assistant Managing Editor of the *New York Times* for presentation to the American Press Institute. In 1945, Mr. McNeil says, there were 46,000 public relations officers in the Federal Government—46,000 potential writers of news releases—enough writers to staff every newspaper in the country twice over. But that's only the beginning. In New York City alone, Mr. McNeil says, there are 30,000 private press agents, all of whom at one time or another are likely to be preparing news releases. All in all, throughout the country, the number of persons preparing news releases is estimated to outnumber working newspapermen ten to one. It's enough sometimes to make city editors wish people weren't taught to write. It's so easy. Anyone can do it. You want something in the paper for reasons of your own. Just write it out, put it in an envelope and mail it to the city editor.

These things being true, this question arises: Do you, as Medical Society executives, want to add to the city editor's morning mail?

There is, in truth, another side to the picture. I happened to be one of 26 city editors who discussed this question with Mr. McNeil at the American Press Institute last December. We all aired our grievances regarding public relations officers, press agents, etc. and then came to some rather startling conclusions. First, we agreed that the profession of preparing news releases is one that is here to stay. Second, we agreed that a good public relations man can be a help to a city editor rather than a headache. Third, we agreed that if public relations men were to become so, it was up to the working newspaperman to help them.

Why aren't public relations men usually a help to the city editor? First, it's because they are persons employed by, let us say, a certain organization to protect their employer's interest in giving out news. They're unlikely to have the newspaperman's objectivity and detachment. They're interested parties always likely to exaggerate the angle favorable to their employer. The city editor, on the other hand, is thinking in terms of giving his reader news and protecting him from advertising or propaganda. The clash is one on point of view. Therefore, so far as you have any responsibility in connection with news releases, you must know and be familiar with a newspaper point of view.

You must have that point of view if your news release is to contain what the city editor is looking for. The color of the paper isn't important. Neither is the way the release is written nor whether it was prepared on the typewriter. The important thing is having the news point of view.

Let me tell you an unusual incident. One morning, not long after V-E day, a young Army officer was shown to my desk. He was tall, gangling and a little shy, but the ribbons on his chest resembled an artist's palette. As humbly and apologetically as you could possibly imagine, he informed me he was about to become public relations officer for the Military District of Washington.

He hated the idea. He was a combat soldier. He knew nothing of public relations. Could we help him? Could we tell him what he ought to do? He spent that entire day at the Star office. I talked to him about an hour. The rest of the time was spent with the reporter on The Star who handled news concerning the Military District of Washington. I don't know whether he spent as much time in the three other newspaper offices in Washington or not. I do know this, however. Six months later I happened to be with representatives of the other papers when this young officer's name was brought up. Everyone agreed he was one of the best public relations men in Washington.

As one of my competitors remarked: "He's not like a press agent. He's all Army but he knows the newspaper point of view."

Now, to turn to Medical Society news. Perhaps the news releases you send the city editor contain only reports of official actions of your Society or abstracts from papers delivered by physicians before your society.

If this is true, I maintain it's not enough. The Medical Society executive is a liaison man between the medical profession and the public. In other words, the Medical Society executive has obligations to both. You know your obligations to doctors. What I'd like to touch upon is your obligation to the public.

Certainly there is no news of greater interest to the man in the street than news concerning his own health, scientific findings regarding his arthritis, or the development of operating technics that might make him a healthier man. Nevertheless, at the American Press Institute meeting of city editors from all over the country last December, it was generally agreed that in most communities local medical news is usually reported inadequately.

We all know the reasons for this. Doctors don't have the attitude at seeing their names in print that movie stars have. Nor is it entirely the shy aloofness of the medical profession. Too often in the past city editors have assigned reporters unequal to the task of writing medical stories. Often their stories were superficial. Sometimes, unable to understand the jargon of medicine, the reporters even wrote joking stories.

That sort of thing is rarer now. I think the press is growing up. It's a slow process, I'll grant, but it's one the Medical Society executive can help along. The hostility and suspicion the doctor feels toward the press can be lessened and the reporter's understanding of the medical profession can be increased by the simple expedient of bringing the two together.

This has been done in Washington and I would like to say at this point that Mr. Theodore Wiprud, your chairman, is a man who for years has impressed editors and reporters alike with an ideal discharge of his two-way obligation to the medical profession and to the press. Within the past few months he has been largely responsible for adoption of a public relations organization in the District Medical Society that is very near to being perfect. The key, I think, was getting doctors into the same room with city editors and reporters to talk the matter over.

That, I think, is the first requisite that lies behind the news release the city editor is looking for, namely, making sure that there is a background of mutual understanding between the medical profession in your city and the newspapermen. Once that background exists, it may be possible to give the public the local medical news they have a right to read.

The way news releases are written is a matter of small moment. If you're training someone to write them, he need only remember the primer lesson of reporting: That every news story has to tell the five W's: who, what, when, where and why. Beyond that, he need only strive for clarity and simplicity. One of the worst kind of news releases is that which gives the news, not in the language of the man in the street, but in the technical language of the doctor. "Medicalese" should be saved for use in medical journals. It's only fog to the public, and sometimes to the newspaperman, and we all know what can happen in fog. If the word you're about to use isn't one a high school boy would understand, it's best to use another. That would eliminate cardiac, ophthalmology, and poliomyelitis, and if I've mispronounced that word, it only proves my point. If you fail to do this, you are passing on to the reporter who rewrites your news release the job of translating it, which of course raises the possibility of error. Incidentally, however, the fact a news release is rewritten is no criticism of the news release. It may be perfect but it'll ,be rewritten anyhow, either to conform to the style of the individual paper or to make certain the wording is not like that in any other paper.

There is another point about news releases that is often not given consideration. That is the question of release date. The question of newspaper competition must be borne in mind. The city editor of an afternoon paper looks with a colder eye on a news release that has already appeared in a morning paper, and vice versa. The importance of this would vary, of course, dependent on the number of newspapers in a given city and whether they are published in the morning or the afternoon. If the division is equal, two mornings and two afternoons perhaps, then news releases of equal news value should be marked alternately for a.m. and p.m. release.

Let me make several other suggestions:

Let's suppose the morning papers contained news from New York, Baltimore or Rochester about some new operation or some new drug. Can the operation be done by some surgeon in your city? Is the new drug available for use by your neighbor? That's what the newspaper reader wants to know. A news release to the city editor can inform him.

Whenever you have a news release you consider particularly good, telephone the city editor and let him know. It may be he'll want to send someone up to get it rather than waiting for the mail or even your messenger.

Furthermore, if the subject of a news release is controversial or the background extensive, it's always a good idea to set up a discussion conference a few days prior to the date the news is to be released. In this way, editors and reporters can be gotten together with the medical experts to talk over the whole matter. In this way, clarity and understanding are achieved and the danger of error in interpretation prevented.

The White House has learned the value of this policy. Three days before the President's Advisory Commission on Universal Training released its report, Dr. Karl Compton met with the press to talk over all the committee's findings and recommendations.

There is one other field I'd like to mention where Medical Society executives and newspapers can work together. Too often, those outside of newspapers fail to realize the responsibility every worthwhile newspaper feels toward improvement of its community. Many times perhaps, in your medical societies, you may become aware of something that could be done to improve the health of your city. Maybe it requires legislation or perhaps only an aroused public consciousness of certain conditions. What I would like to suggest is that you use the contacts you have formed with newspapers to enlist them in a mutual campaign to achieve the objective.

In a sense, I appear to have wandered far afield from what a city editor looks for in a news release. Not really, however. As I said at the beginning, the city editor is looking for NEWS. The point I want to make now is this: He knows he will find it in a news release prepared against the background I have tried to sketch for you, in the news release that, whether it concerns medicine or law, is created with the understanding of the city editor's task—to put before his readers whatever is of chief value and interest in the record of his city's 24 hours.

WARTIME EMIC PROGRAM TERMINATED

The books for the Emergency Maternity and Infant Care program are being closed, with a record of 1,421,000 cases completed or approved for care from March 1943 to June 30, 1947, the U. S. Children's Bureau, Social Security Administration, Federal Security Agency, announced today.

This wartime program, under which maternity care was provided for servicemen's wives and medical, hospital and nursing care for their infants throughout the first year of life, is being liquidated, starting July 1, after more than four years' operation. The books will not be finally closed, however, for at least another 21 months, for the full term of care is still to be provided for all wives and infants now receiving care, and for all those eligible for care as of June 30.

Wives and infants of men in the four lowest pay grades of the armed services, and of aviation cadets have been eligible in the care provided under EMIC. The programs have been administered by State health departments under plans approved by the Children's Bureau.

The Emergency Maternity and Infant Care program has been drawing to its end for some time. Cases accepted for care under the program dropped to an average of 9,300 a month in 1947, in comparison with 47,000 during the peak month of the war period. Of the current average monthly cases authorized, 5,500 are for maternity care, the remainder being for the care of infants. From the beginning of the program to June 30 this year, infants for whom care has been authorized totalled about 217,300; maternity cases, over 1,203,500.

Congress, in directing the program's liquidations, specifically continued the program for all wives and infants for whom care is already authorized, and also brought under the program any serviceman's wife and child if she was pregnant June 30, 1947, even though application had not been made before that time. She can apply for and receive for herself and infant the full services provided for under the EMIC program until the child is 1 year of age. Applications can be made to her own physician or to the local or State health department. There is one exception to the foregoing. The State of Arkansas, through the action of its State board of health, indicated that it would not accept any applications for care made after May 31, 1947.

Starting out as an emergency measure, this program turned out to be the largest public medical care program for mothers and children ever undertaken in this country. At the height of the program one out of every seven babies born in the United States was born under the EMIC program. Over 48,000 doctors in private practice and hospitals all over the country were coöperating in the EMIC program in the fiscal year 1945. Even under wartime difficulties, an all-time record was set for hospital births in this country. More than 92 out of 100 babies born under the program in 1945 were born in hospitals. Of all babies born in the United States that year only 79 out of 100 were born in hospitals, and even that proportion was high in comparison with the prewar number. Many of the mothers who were delivered in hospitals under the EMIC program, the Children's Bureau pointed out, were from population groups that ordinarily had their babies at home, and sometimes had not even a doctor, but only an untrained midwife, in attendance.

To June 30, 1947, over $124,900,000 had been allotted to the States to cover the cost of the program. For the two fiscal years 1947–48 and 1948–49, Congress has appropriated another $3,000,000, to be used in liquidating the program. During the past 6 months, the cost of delivery has averaged about $100 a baby; the average cost of caring for a sick infant, $67. Of the total amount disbursed by the States up to the present time, hospitals have received approximately $63,500,000; doctor bills have totalled $50,500,000.

Federal funds in the total amount of $1,052,748 had been allotted to the District of Columbia through June 30, 1947. Since June 1943, when the plan for the District was approved, 10,540 cases for maternity care and 2,300 cases for infant care had been authorized through June 30, 1947 (June 1947 estimated).

VAST SUMS FOR CANCER RESEARCH APPROPRIATED

With the passage by Congress of legislation more than tripling appropriations for research and control of cancer, and bringing next year's budget of the National Cancer Institute in Bethesda, Md., to the all-time high of $14,000,000, the U. S. Public Health Service announces plans for an expanded attack on the cancer problem that will place cancer in the forefront of the Government's medical research and control programs.

Under the broad authority provided in Public Health Service Law and the Appropriation Act, support may now be extended to universities to assist them in developing greatly expanded cancer research and training programs. The law also supports the acquisition of land and construction of buildings when urgently needed. Evidence of the over-all desire on the part of the Congress and the President to provide continuity in cancer research is shown in a provision of the Act, under which funds for cancer research and training grants remain available until spent.

Already the National Advisory Cancer Council of the Institute has recommended greatly increased grants-in-aid to outside institutions engaged in experiments to find the cause and cure of cancer. With the passage of the Appropriations Act a total of 46 project grants, involving the expenditure of $594,348 was made to widely scattered groups. In all, 35 institutions in 23 states are recipients. At the same time the Institute is greatly expanding its own research program at Bethesda, where there will be increased emphasis on clinical research.

Three local institutions will benefit from the grants-in-aid. The projects approved for the District of Columbia are as follows:

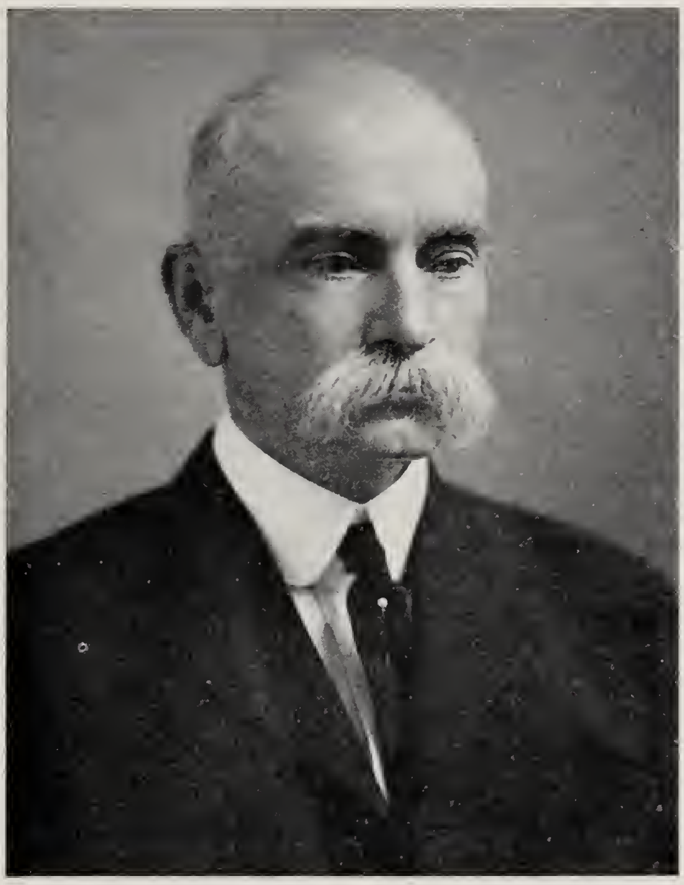
"An Inventory of Tissue Regeneration in Benign and Malignant Tumors," $5,000, Dr. Charles F. Geschickter, Georgetown University School of Medicine.

"Endocrine Aspects of Cancer," $12,636, Dr. Harold Jeghers, Georgetown University School of Medicine.

"Specific Studies in the Diagnosis and Therapy of Clinical Cancer," $25,737, Dr. Calvin T. Klopp, Warwick Memorial Clinic for Cancer and Allied Diseases. This fund will be used to finance three major studies: Dr. Roy Hertz will investigate the effect of sex hormones on breast and prostate cancer; Dr. Louis Alpert will study the effect of nitrogen mustard and related compounds on cancer; Dr. Karl Wood, a dentist, will develop artificial facial features to replace those removed by surgical treatment of cancer. While the research will be directed by the

(*Continued on page 467*)

Washington Physicians of Yesterday



JOSEPH FORD THOMPSON, M.D., LL.D.

Dr. Joseph Ford Thompson was born March 20, 1837, in Saint Mary's County, Maryland, a couple of miles from Leonardtown. From the University of Maryland he received the degree of M.D. in 1857, and of LL.D. in 1907. In 1860 he married Marion Virginia Grieves, by whom he had a daughter who became the wife of Dr. Thomas Eugene McArdle (1852–1926) of this city.

During the Civil War Dr. Thompson served from June, 1862 to August, 1865 as Acting Assistant Surgeon, United States Army, in the military hospitals of Washington. Thereafter until his retirement in 1907 he engaged in the exclusive practice of surgery in Washington, and he was preëminent in that field in the city. He had superior diagnostic judgment and operative skill. He kept well abreast of surgical progress, and studied abroad in 1871 and 1882 in the great surgical clinics of Europe. He was surgeon to most of the hospitals of Washington. He was Professor of Anatomy, 1865–1872, and of Surgery, 1872–1907, in the Columbian Medical College (later George Washington University). He was an efficient teacher, forceful and impressive. On account of ill health he retired from active practice in 1907; he died February 1, 1917.

(*Continued on page 468*)

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News and Personals

The 33rd Annual Clinical Congress of the American College of Surgeons, including the **26th Annual Hospital Standardization Conference,** will be held at the Waldorf-Astoria, New York, from September 8–12. The five-day program features operative and nonoperative clinics in 38 hospitals in New York and Brooklyn. Scientific sessions in general surgery and the surgical specialties, official meetings, hospital conferences, medical motion pictures, and educational and technical exhibits will be held at the headquarters hotel.

The Third American Congress on Obstetrics and Gynecology will convene in the Municipal Auditorium in St. Louis, Missouri, September 8–12, 1947. The program is designed not only for the specialist in this field but for all doctors, nurses, hospital administrators, public health workers and medical educators who are interested in the care of the mother and child. Information concerning registration fees, hotel reservations and further details about the program may be obtained from the office of the Congress at 24 West Ohio Street, Chicago 10, Ill.

The American College of Chest Physicians is sponsoring a second annual Postgraduate Course in Diseases of the Chest to be held in Chicago during the week of September 15–20, 1947, at the Municipal Tuberculosis Sanitarium. The course will be limited to 30 physicians; the tuition fee is $50. Further information may be secured from the office of the College, 500 North Dearborn Street, Chicago 10, Ill.

The 48th Annual Meeting of the American Roentgen Ray Society will be held in Haddon Hall in Atlantic City, September 16–19. More than 1,000 specialists in X-ray and radium are expected to attend this meeting.

The 49th Annual Convention of the American Hospital Association will be held in St. Louis, Mo., September 22–25. Among Washington hospital administrators who will participate in the program are A. B. Cook, of Garfield Memorial Hospital; James G. Capossela, Emergency Hospital; and Karl H. York, Arlington Hospital.

The United States Chapter of the International College of Surgeons will hold its 12th Annual Assembly and Convocation at the Palmer House and Stevens Hotel, Chicago, the week beginning September 28. **Dr. Custis Lee Hall,** President-elect, will take office as President. The new library and permanent home of the U. S. Chapter will be formally dedicated.

In addition to Dr. Hall, three other Medical Society members will participate in the program: Rear Admiral Clifford A. Swanson, Surgeon General of the Navy; Dr. Charles Stanley White, who will speak on "Preservation of the Anal Sphincter in Recto-Sigmoid Resections"; and Dr. James W. Watts, who will discuss "Prefrontal Lobotomy—the Complications and Their Treatment." On October 3, Cook County Hospital Day, Dr. Hall will lead a round table discussion on orthopedic problems.

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1948 to June 30, 1949. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in internal medicine. Assurance must be provided that the applicant will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work. The stipend will be from $2,200 to $3,000. Application forms will be supplied on request to the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa., and must be submitted in duplicate not later than November 1, 1947.

The Annual meeting of the American Board of Obstetrics and Gynecology was held in Pittsburgh, Pa., from June 1–7, at which time 250 candidates were certified. Drs. Roland E. Bieren, Edmund F. Daley, Morton S. Kaufman, William T. Lady, Thomas M. Leonard, Jed W. Pearson, Jr., Barton W. Richwine, George T. Sharp and John W. Walsh, of Washington, D. C., were among the certificants.

A number of changes in Board regulations and requirements were put into effect. Among them was the new ruling that the Board does not subscribe to any hospital or medical school rule that certification is to be required for medical appointments in ranks lower than Chief or Senior Staff of hospitals, or Associate Professorship in Schools of Medicine, for the obvious reason that such appointments constitute desirable specialist training. At this meeting the Board also ruled that credit for graduate courses in the basic sciences which involve laboratory and didactic teaching rather than clinical experience or opportunities will be given credit for the time spent up to a maximum period of not more than six months regardless of the duration of the course.

The next written examination (Part 1) for all candidates will be held in various cities of the United States and Canada on Friday, February 6, 1948, at 2 p.m. The closing date for applications is November 1, 1947. Application blanks may be secured by writing to Dr. Paul Titus, Secretary of the Board, 1015 Highland Building, Pittsburgh 6, Pa.

The AMA Bureau of Health Education announces a change in time for its weekly radio dramatization "Stephen Graham, Family Doctor," which has been extended to November 17. The program will go on the air each Sunday afternoon at 3 p.m., Eastern

The Society of Registered X-Ray Technicians of Washington will meet in the Medical Society's Library, September 9, at 8 p.m. Mr. J. J. Maguire of the North America Phillips X-Ray Corporation of New York City will speak on "Near-future Aspects of Radiation." Radiologists and any other interested physicians are invited to attend.

The American Medical Association, at the request of Secretary of the Interior Krug, has established an advisory committee to undertake surveys of health problems in the territories and island possessions of the United States and other areas under the jurisdiction of the Department of the Interior. The first team appointed by this committee left Minneapolis on July 19 for Anchorage, Alaska. **Dr. William A. Morgan,** of Washington, is the Executive Secretary of the Advisory Committee, which is made up of the following physicians: Drs. R. L. Sensenich, South Bend, Ind., Elmer L. Henderson, Louisville, Ky., William F. Braasch, Rochester, Minn., and George F. Lull, Morris Fishbein and E. E. Irons, Chicago. Dr. Morgan during the early years of World War II made a health inspection survey for the Government in Alaska and is familiar with the problem. He has been a consultant on health matters for the Department of the Interior and is associated with the staffs of several hospitals in the Metropolitan Washington area.

A list of professional motion picture films now available has just been compiled by the Academy-International of Medicine, 214 West Sixth Street, Topeka, Kansas. The list is indexed by topics and includes the source from which the films may be obtained by the borrower. A complimentary copy of the AIM Medical and Surgical Film Catalogue will be mailed upon request to any member of the District Medical Society.

The First Pan American Congress of Pediatrics closed its four-day convention at the Mayflower Hotel, July 12, having registered an attendance of more than 600 delegates and visitors. Dr. Felix Hurtado, of Cuba, was the Chairman of the Congress.

At the banquet, which was the final event, Dr. Joseph S. Wall, Past President of the American Academy of Pediatrics, and Dr. Clifford G. Grulee, of Evanston, Ill., Executive Secretary of the Academy, were presented with the Carlos J. Finlay Award for contribution to Cuban sanitation and public welfare. Dr. Wall received the rank of Commander in the Finlay Order and Dr. Grulee the rank of Official. Drs. Wall and Grulee, together with Dr. Henry F. Helmholz, of the Mayo Clinic, Rochester, Minn., were made honorary members of the Latin-American Division of the Academy.

Dr. Wall and Dr. Marion M. Crane, of the Children's Bureau, were among the local physicians who appeared on the program. Members of the Washington Committee on Arrangements for the Convention were Dr. Edgar P. Copeland, Chairman; Dr. Harry A. Ong, Assistant Chairman, Drs. Margaret M. Nicholson, William F. Burdick, Richard H. Todd, Hugh J. Davis, William F. O'Donnell and Ferando Leiva. Mrs. Joseph S. Wall was Chairman of the Women's Committee.

Mexico City was selected by the delegates as the site of the next Congress in 1949. Dr. Frederico Gomez, Chairman of the Mexican Committee, responded to the announcement of the selection in behalf of his country.

Several of the smaller medical societies have elected new officers for the coming year.

The Medical College of Virginia alumni held their annual dinner meeting at the Washington Golf and Country Club. Among the speakers at the dinner meeting were Dr. Harvey Haig, Dean of the School of Medicine, who was present for the occasion, and Dr. Harry Lee Claud, newly elected President of the national medical alumni.

The new officers elected were:

Dr. LeRoy L. Sawyer, *President;* Dr. Thomas Pumphrey, *Vice President;* Dr. Charles P. Ryland, *Secretary-Treasurer.*

On July 3 the **D. C. Rheumatism Society** adopted the proposed Constitution and reëlected all officers. They are:

Dr. Darrell C. Crain, *President;* Dr. Charles H. McEnerney, *Vice President;* Dr. Milton C. Cobey, *Secretary-Treasurer.*

New officers for the **Washington Ophthalmological Society:**

Dr. Edward J. Cummings, *President;* Dr. Jerome A. Sansoucy, *Vice President;* Dr. John T. Schnebly, *Secretary-Treasurer.*

The Washington Gynecological Society has named the following new officers:

Dr. William J. Cusack, *President;* Dr. Jacob Kotz, *Vice President;* Dr. Herbert P. Ramsey, *Secretary;* Dr. George Nordlinger, *Treasurer;* Dr. David H. Kushner, *Historian.*

The Section on Neurology and Psychiatry sponsored a special meeting of psychiatrists from the District of Columbia and nearby states, June 27, in the Medical Society's building. The meeting was held to discuss "Mental Health and World Citizenship" in preparation for the forthcoming Third International Congress on Mental Health and in coöperation with the World Health Organization.

Dr. Samuel W. Hamilton, Past President of the American Psychiatric Association, presided. He was assisted by Dr. Frank Fremont-Smith, Vice President for the United States of the World Federation for Mental Hygiene. Among those who led in the discussion were Dr. Winfred Overholser, President of the American Psychiatric Association and Superintendent of St. Elizabeths Hospital; Dr. Daniel Blain, Chief, Neuropsychiatry Division, Veterans Administration; Dr. Harry Stack Sullivan, Editor of *Psychiatry;* Dr. Grace Baker of Baltimore, who substituted for Dr. George H. Preston, Commissioner of Mental Health for the State of Maryland; and Dr. David C. Wilson, Professor of Psychiatry, University of Virginia Medical School, Charlottesville.

In accord with the Hospital Survey and Construction Act of 1946, the District Commissioners have appointed a **Hospital Advisory Council** to serve in an advisory capacity to Dr. George C. Ruhland, District Health Officer, in planning hospital construction. The first meeting was held June 19 at the Municipal Center.

The Council includes representatives of non-Governmental organization, agencies concerned with operation of hospitals, and consumers of hospital services. Representing the first of these groups are Dr. William P. Herbst, retiring President of the District Medical Society; Dr. A. Clagett Gray, also from the Society; and Dr. William C. Goines, of the District Medico-Chirurgical Society.

Dr. Alvin R. Sweeney, Superintendent of Gallinger Hospital, and Colonel Kenneth E. Madsen, Assistant Engineer Commissioner, will represent the agencies concerned with hospital operations.

Representatives of the consumer hospital services are Dr. Herbert P. Ramsey, of the Washington Metropolitan Health Council; Mr. Clifford Newell, President of the Federaton of Citizens' Associations; Mr. F. H. Kenworthy, Chairman of the Public Health Committee, Board of Trade; and Dr. Jesse A. Keene, Committee on Public Health, Federation of Civil Organizations.

Among the faculty members of **George Washington University School of Medicine** who received promotions recently were ten members of the Medical Society. They are as follows: Dr. James W. Watts, from Clinical Professor of Neurosurgery to Professor of Neurological Surgery; Drs. Louis K. Alpert, James J. Feffer and Lawrence E. Putnam, from Clinical Instructor in Medicine to Associate; Drs. Paul Chodoff and Robert H. Groh, from Clinical Instructor in Neurology to Associate, Dr. Edward A. Cafritz, from Clinical Instructor in Surgery to Associate; Dr. Clayton B. Ethridge, frcm Assistant Clinical Professor in Medicine to Associate; Dr. John H. Lyons, from Associate Clinical Professor of Surgery to Clinical Professor; and Dr. George D. Weickhardt, from Clinical Instructor in Dermatology and Syphilology to Clinical Instructor in Neurology.

A new medical journal, *Medical Arts and Sciences*, A Scientific Journal of the College of Medical Evangelists, has appeared in the Society's offices. It will be a quarterly publication. Dr. Walter E. Macpherson is Editor-in-Chief; Dr. J. Wayne McFarland, an Associate member of the District Medical Society, is House Editor.

Twenty visiting European pediatricians were entertained at a luncheon at the Mayflower Hotel on Sunday, July 27, by members of the Section on Pediatrics. **Dr. Margaret M. Nicholson** was in charge of arrangements.

Dr. A. C. Ivy, Vice President of the University of Illinois, will succeed Dr. George M. Smith as Executive Director of the **National Cancer Advisory Council.** Dr. Smith resigned some months ago for reasons of health.

Dr. Ivy is well known in the scientific field for his contributions in physiology of the gastrointestinal hormones. With his co-workers at Northwestern University, where he formerly served as head of the Department of Physiology and Pharmacology, he was largely responsible for the discovery and isolation of the hormone now known as entrogastrone. He has recently served as one of the expert witnesses in the Nuremburg trials in Germany.

Dr. Herman E. Hilleboe, Assistant Surgeon General of the United States Public Health Service and Associate Chief of the Bureau of State Services, was appointed by Governor Dewey to the office of Commissioner of Health of New York State. He took office July 1.

Dr. Hilleboe has been prominent in the field of tuberculosis control for several years past. He came to Washington in July 1944 as the first director of the Tuberculosis Control Division of USPHS. In this office he administered a nationwide campaign against tuberculosis. He was appointed Assistant Surgeon General in November 1946.

As one of a committee of four experts on tuberculosis he represented the United States at a meeting in Paris, July 3), sponsored by the Interim Commission of the World Health Organization. Just previous to this assignment he represented the National Tuberculosis Association of the United States at a Council of the International Union against Tuberculosis, which was also held in Paris. He took an active part in the recent meeting of the National Tuberculosis Association in San Francisco, June 16–19 , where he discussed the Federal Hospital Survey and Construction Act.

Dr. Hilleboe is a member of the Board of Directors of the NTA and an Associate member of the District Medical Society. He graduated from the University of Minnesota School of Medicine in 1931 and received the degree of Master of Public Health from Johns Hopkins in 1935.

Vice Admiral Ross T. McIntire, former Surgeon General of the Navy, has been named Director of the new National Blood Program of the American Red Cross. The new program has been developed to provide blood and its derivatives, without charge, to the entire Nation.

Dr. McIntire recently received the French Government's Legion of Honor, Grade of Officer, for achievement during World War II.

Dr. William W. Stanbro, who has just completed residence on a fellowship at the Mallinckrodt Institute of Radiology, Washington University, St. Louis, has been named chief roentgenologist at the George Washington University Hospital and Assistant Professor of Radiology at the School of Medicine. Dr. Stanbro began his new duties at the Hospital, July 15. He received his medical education at Washington University. During the War he was attached to the Radiology Department of the 21st General Hospital (Washington University Unit).

Drs. Norvell Belt, William P. Herbst and Lloyd G. Lewis were among those invited to discuss papers presented during the 42nd Annual Meeting of the American Urological Association in Buffalo, New York, June 30 and July 1–3.

At the business meeting, **Dr. William D. Jarman** was elected to active membership in the Association; the names of **Drs. Edward E. Ferguson and Oliver Earl Thompson** were presented for membership.

Dr. Paul R. Hawley, Chief Medical Director of Veterans Administration, has been awarded the Gorgas Award for 1947. The recipient of this award, who is selected annually by the Executive Council of the Association of Military Surgeons, must have made a notable contribution in the field of military medicine. Formal presentation will be made at the Association's annual meeting in Boston, November 13–15. Dr. Hawley, who retired from active duty with the Army on June 30, 1946, with the rank of Major General, was officer-in-charge of all medical care in the European Theater of Operations during World War II. Sponsor of the Gorgas Award is Wyeth, Inc., of Philadelphia.

Dr. R. C. Williams, Assistant Surgeon General of the U. S. Public Health Service, has accepted appointment as a member of the Board of Directors of the Music Research Foundation, Inc., a nonprofit organization which has for its purpose the study of the use of music in the treatment of disease. Dr. Williams will act as Chairman of the Executive Committee of the Board of Directors.

The Reverend Dr. Thomas Verner Moore, who has been an Associate member of the District Medical Society since 1917, has entered the Cartuja de Miraflores Carthusian Monastery near Burgos, Spain.

Dr. Moore had been affiliated with Catholic University almost continuously in some capacity since 1896. He received the degree of Doctor of Philosophy from that institution in 1903, and a degree in medicine from Johns Hopkins University in 1915. In 1916 he was appointed Associate Professor of Psychology at Catholic University; since 1939 he has served as head of the Child Center at the University and as Director of the Department of Psychiatry and Psychology.

Last January, upon invitation from the Spanish Ministry of Education, Dr. Moore left for Spain to give a series of lectures at Madrid University as a visiting professor of psychology and psychiatry. He was awarded a medal of the Spanish Council of Scientific Investigation.

Dr. Francis J. Eisenman retired as Administrator of **Garfield Memorial Hospital,** July 1, and has been succeeded by **Arkell B. Cook**. Dr. Eisenman has concluded 23 years of service at Garfield, including 17 years as Administrator.

Mr. Cook was associated with the University of Michigan Hospital in Ann Arbor as Assistant Director from 1940 to 1945, when he became Superintendent of the Monmouth Memorial Hospital in Long Branch, N. J. He is a graduate of the University of Michigan.

Drs. Frank E. Gibson, Sr. and Herman E. Kittredge are retiring from active practice. Both graduated from Columbian Medical School (now George Washington University) and both have practiced in this community since 1901, a combined total of 92 years' service.

Dr. Gibson, a general practitioner, has maintained the same office at 927 Eye Street, N. W. where he started his practice in 1901. He is a Life member of the Society and Permanent Treasurer of the Washington Medical and Surgical Society, an office he has held since 1903. His present address is Apartment 21, 4225 South Four Mile Run Drive, Arlington, Va.

Since 1929 Dr. Kittredge has maintained his office at 1835 Eye Street, N. W., specializing in dermatology. He has now moved to Oak Haven, Clinton, Maryland.

Dr. Eugene deSavitsch participated in the recent meeting of the National Tuberculosis Association in San Francisco. In a Symposium on Antibiotics and Chemotherapy in Tuberculosis, June 18, he opened the discussion with a paper entitled "An Antibiotic Precursor of Streptomycin."

Lt. Commander John L. Conley advises that he transferred to the Regular Navy in June. At present he is stationed at the U. S. Naval Dispensary and resides at 2032 Allen Place, N. W. Dr. Conley has served with the U. S. Naval Reserve since November, 1942.

Dr. James J. Feffer, Vice President of the District Tuberculosis Association, discussed the proposed mass X-ray survey over Station WINX on June 15.

Dr. William C. Meloy gave a talk on plastic surgery on a radio broadcast over WMAL, June 19, during "The Modern Woman" program.

BOWLING LEAGUE POSTSCRIPT

Much curiosity has been aroused over the identity of the winning Sibley No. 2 team members who led the D. C. Medical Bowling League at the conclusion of last year's matches.

It has been rumored that this curiosity has been stimulated by the members themselves of the leading team, who have been heard to mutter, "They never even mentioned our names and we may never lead the League again."

Well, boys, here they are. The leaders of the League were the following well known medicos: Dr. George H. McLain, Captain, and Drs. Willis B. Morse, J. Phelps Hand, Sollie Katzman, and Raymond C. Kirchner, team members.

Incidentally, Sibley No. 2 won high team game with a score of 630. Mt. Alto won high team set with 1718.

The final standings were as follows:

Team	*Won*	*Lost*
Sibley No. 2	56	22
Prince Georges	50	28
Mt. Alto	46	32
Suburbanites	46	32
Garfield No. 2	45	33
Doctors	44	34
Georgetown	41	37
Sibley No. 1	38	40
George Washington	36	42
Garfield No. 1	34	44
Providence	30	48
Children's	28	50
Good Hopers	27	51
Columbia	26	52

CORRESPONDENCE

TREATMENT OF SYPHILIS

WASHINGTON, D. C., July 3, 1947

THE EDITOR
MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA
1718 M STREET, N.W.
WASHINGTON 6, D. C.

DEAR SIR:

In the MEDICAL ANNALS for June 1947, Volume 16, Number 6, page 325, appears a brief note on the penicillin treatment of syphilis by Dr. F. J. Eichenlaub. These remarks could possibly be amplified so as to make clear the basis of the present-day treatment of syphilis.

If patients are being treated with weekly injections of penicillin, this treatment is being given without any precedent since there is nothing in the literature which would indicate that this method of treatment is either effective or ineffective. The directions for use which appear in the labeling for penicillin products are approved by the Food and Drug Administration before these products can be shipped in interstate commerce. The directions for the use of penicillin in syphilis which appear in the circulars are based on an article entitled "Commercial Penicillin" which was prepared by the Committee on Medical Research of the Office of Scientific Research and Development, the United States Public Health Service, and the Food and Drug Administration. This article appeared on page 271 of the *Journal of the American Medical Association,* May 25, 1946.

On page 273 there is a paragraph which outlines certain suggestions as to the use of penicillin in syphilis. It recommends a minimum dose of 3.6 million units for seronegative primary syphilis and 5.4 million units for seropositive primary and early secondary syphilis. These injections are recommended every two to four hours, preferably every two to three hours daily, around the clock, for a minimum of seven and one-half to eight days.

A suggested schedule is also given using penicillin in oil and wax: "If calcium penicillin in peanut oil-beeswax is used in any stage of syphilitic infection, the average daily dose for an adult should be 2 c.c. (600,000 units) and the total duration of treatment from eight to fifteen days or longer, depending on the stage of the infection. For early syphilis a minimum total dose of 4.8 to 6.0 million units of this preparation is advised. Calcium penicillin in peanut oil-beeswax should not be administered by the subcutaneous route, since under these circumstances the incidence of sensitizing reactions, with giant urticaria and angioneurotic edema, is excessively high."

For a first relapse of early syphilis it was recommended that the penicillin be repeated, together with 360 mg. of oxophenarsine hydrochloride given two or three times weekly in six individual injections of 60 mg. each plus 1,200 mg. of bismuth subsalicylate given twice weekly in six individual intramuscular injections of 0.2 gram each.

Other dosage schedules are listed for a second relapse and later stages of syphilis and for the treatment of infants with congenital syphilis.

It was emphasized in this article that these suggestions for the use of penicillin in syphilis represented a combination of medical desirability and expediency and were based upon information available at that time, were only tentative, and were subject to revision as further information accumulated. It was also most vigorously emphasized that in the adoption of penicillin therapy for syphilis, the eventual value of which will not be determined for several years to come, the physician had a particular responsibility for careful follow-up and frequently repeated post-treatment observation on all patients so treated.

On April 17, 1947 a symposium entitled "Recent Advances in the Investigation of Venereal Diseases" was held under the auspices of the Syphilis Study Section, Research Grants Division of the National Institute of Health, U. S. Public Health Service, in the auditorium of the Federal Security Building, Washington, D. C. At this symposium it was brought out that no improvement in two-year follow-up could be obtained after giving 1.2 million units of penicillin over a period of four to fifteen days by (1) increased dosage of penicillin; (2) addition of the amounts of arsenic recommended above; (3) addition of the amounts of bismuth recommended above; (4) a combination of (2) and (3). However, the important fact was stressed that the relapse-reinfection rate at the end of two years was 25 to 30 per cent.

In view of the fact that some competent observers have found over 90 per cent cures with penicillin alone, there is a definite question as to whether or not the relapse-reinfection rate is composed mainly of reinfections rather than relapses. I shall not discuss the effect on promiscuity of a quick, easy cure for syphilis, but it should be evident to all concerned.

On the basis of the above facts the Food and Drug Administration is currently recommending to manufacturers that circulars for penicillin include a recommendation that if penicillin is relied upon in the treatment of syphilis the relapse-reinfection rate may be 25 to 30 per cent at the end of two years. If the physician feels that this rate is due to relapse, he could give either a second course of penicillin with or without the amounts of arsenic and bismuth suggested above or the standard Army-Navy twenty-six weeks' course of arsenic and bismuth (forty intravenous injections of oxophenarsine hydrochloride and sixteen intramuscular injections of bismuth subsalicylate). If, however, he believes that these are mostly reinfections as is suggested by recent work (which is not as yet conclusive), he may rely on penicillin alone, using a dose of at least 1.2 million units over a period of one week. However, the physician is cautioned to carry out monthly serologic tests for syphilis (preferably one or more quantitative tests) for at least one year. If a rising titer is obtained it would seem advisable to make use of one of the retreatment schedules. While this procedure may not be followed by the investigator who is studying groups of patients for the long-range effect of penicillin in syphilis, we believe the individual patient of the private physician deserves this retreatment.

Although schedules are under investigation involving the use of penicillin at infrequent intervals over a long period of time, no information is available at present on their value. Consequently, it would be definitely unwise, as stated by Dr. Eichenlaub, for the practitioner to use them.

Very truly yours,
LAWRENCE E. PUTNAM, M.D.
Acting Medical Director,
Food and Drug Administration

CHICAGO, ILLINOIS, July 16, 1947

MR. THEODORE WIPRUD
MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA
1718 M STREET, N.W.
WASHINGTON, D. C.

DEAR MR. WIPRUD:

Several days ago I was reading the January issue of your journal and, after reading the scientific articles, turned automatically to IN AND OUT OF FOCUS, which I enjoy immensely. Among the quotations was one from my article on the life expectancy of physicians. To refresh your mind, it began as follows: "In 1945, their average age at death was 65.3 compared with 64.9 among the millions of industrial policyholders of the Metropolitan Life Insurance Company."

I made a slight error in this statement which it is only fair to rectify. The figures are correct but the 64.9 is the life expectancy instead of the average age at death. The insurance company is now trying to calculate what the life expectancy is for physicians. I do not know what the exact answer will be, but think it will be higher. If so, it will substantiate my contention that physicians have a greater life expectancy than the general population.

I would like to add that I consider your journal one of the finest in America. It covers medicine thoroughly and is unusually well edited.

Sincerely,
T. R. VAN DELLEN, M.D.
How To Keep Well Department,
Chicago Tribune

BOOK REVIEW

A Textbook of Medicine, 7th ed., edited by RUSSELL L. CECIL, A.B., M.D., Sc.D., Professor of Clinical Medicine, Cornell University Medical College; Consulting Physician, New York and Veterans' Hospitals; Visiting Physician, Bellevue Hospital, New York City; with the assistance of WALSH MCDERMOTT, M.D., Associate Professor of Medicine, Cornell University Medical College, AND HAROLD G. WOLFF, M.D., Associate Editor for *Diseases of the Nervous System;* Associate Professor of Neurology, Cornell University Medical College. Price, $10.00. Pp. 1730, with 244 illustrations. Philadelphia: Saunders, 1947.

The newest edition of this book is at least as good as previous editions in spite of the exigencies of war which added greatly to the difficulties of revision. There are advantages in the preparation of a text by experts in each disease or group of diseases. On the other hand, a certain continuity is apt to be lost in spots because it is almost impossible for one man to weave the theses of one hundred and sixty-two authors into a uniform style. Thus certain teaching values may at times be lost. Naturally some sections are better and more up-to-date than others. Improvements are possible and could be pointed out. On the whole, however, the book is an excellent one.

W. M. Y.

BENJAMIN FRANKLIN IDEN, JR., A.B., M.D.

(1883–1947)

Dr. Benjamin F. Iden, an active member of the Medical Society of the District of Columbia, died July 6 at his apartment at 3601 Connecticut Avenue, N. W. His office was located at 1726 Eye Street, N. W.

A native of Manassas, Virginia, born August 27, 1883, Dr. Iden was the son of a physician, Dr. Benjamin F. Iden, and Mrs. Virginia Hooe Iden. He received his A.B. degree from the University of Virginia and his medical degree from the same institution, the latter in 1909. He enrolled for postgraduate work at the New York Post-Graduate Hospital in 1913.

From 1909 until 1913 he practiced medicine in Manassas, Virginia. At the outbreak of World War I he enlisted in the U. S. Navy and served aboard troop transports. From 1921, when he resigned from the Navy, until his death he practiced medicine in the District of Columbia.

Dr. Iden was a member of the American Medical Association, and a member of the District Medical Society since 1922. He was also a 32nd degree Mason.

Surviving are his wife, Mrs. Pauline N. Iden; a brother, Dr. John Iden, of Manassas, Va.; and three sisters, Mrs. M. I. Ballard, Mrs. Harold Benoist and Mrs. Joseph C. Bennett, of Washington.

Metopon Hydrochloride

(*Continued from page 443*)

5. HIMMELSBACH, C. K.: Studies of certain addiction characteristics of dihydromorphine ("paramorphan"), dihydrodesoxymorphine-D ("desomorphine"), dihydrodesoxycodeine D ("desocodeine"), and methyldihydromorphinone ("metopon"). J. Pharmacol. & Exper. Therap., 1939, **67**, 239.
6. LEE, L. E., JR.: Medication in control of pain in terminal cancer, with reference to study of newer synthetic analgesics. J. A. M. A., 1941, **116**, 216.
7. LEE, L. E., JR.: Studies of morphine, codeine and their derivatives; clinical studies of morphine, methyldihydromorphinone (metopon) and dihydrodesoxymorphine-D (desomorphine). J. Pharmacol. & Exper. Therap., 1942 **75**, 161.

Appropriations for Cancer Research

(*Continued from page 456*)

Clinic, the facilities of Garfield Hospital will be used.

"Correlation of Structure with Biological Action of Chemical Compounds," $27,000, Dr. Walter R. Kirner, National Research Council.

Four million dollars of the increase in NCI's budget will go—not to research—but to cancer control, the program administered through the states to increase the effective use of present methods of diagnosing and treating cancer. It is estimated that while a fourth of cancer patients are cured today, another fourth could be cured if they received early treatment.

The cancer control program will place emphasis on the improvement of cancer detection, diagnostic and treatment facilities; the development of refresher courses for doctors; the establishment of adequate statistical services on cancer; and the setting up of cancer control units in state Health Departments.

In connection with the expanded research program, the appointment of Dr. Harry Eagle as director in charge of research within the Institute, and of Dr. David E. Price in charge of cancer research grants, has been announced by Dr. Leonard Scheele, recently appointed Chief of the National Cancer Institute. Dr. Austin V. Deibert also joins the program in charge of cancer control.

Dr. Eagle comes to the Institute from Baltimore where he was Director of the Laboratory of Experimental Therapeutics, a joint project of the U. S. Public Health Service and the Johns Hopkins School of Hygiene. He has made important research contributions in immunity and serologic tests for syphilis, and received the Alvarenga Prize of the College of Physicians of Philadelphia for a paper on blood coagulation. He is also known for his work in chemotherapy with particular reference to syphilis and a number of tropical diseases including sleeping sickness.

Washington Physicians of Yesterday—Thompson

(*Continued from page 457*)

Dr. Thompson became a member of the District of Columbia Medical Society in 1864, and was an extremely active and devoted participant in its meetings and affairs, both in committee service and its scientific proceedings. He was President of the Society in 1878, and of the District Medical Association in 1881–82. Previous to his admission to membership the proceedings of the Medical Society had been quite sterile and perfunctory; but about that time he with a group of other ardent young spirits stimulated and vivified the organization by instituting frequent meetings for the presentation of vigorous scientific programs. That group made an abiding impress on the spirit and fabric of the Society. He was a faithful attendant at the meetings of the Society, and to its scientific proceedings he contributed a rich profusion of case reports, specimens, and comment. He was averse to preparing and publishing formal papers; and it was only through personal pressure that he was induced to present a paper on the "History of the Hospitals of the District of Columbia" at an anniversary celebration in 1894.

A conspicuous characteristic of Dr. Thompson was his forceful personality. Physically well built, tall, erect, always so faultlessly attired as to excite admiring comment, earnest, grave, dignified, cultured, Dr. Thompson was an outstanding figure in any assemblage, a man to inspire respect and esteem. A ready, fluent, incisive, and even sarcastic speaker, he had positive opinions, which he unhesitatingly expressed with impressiveness and force. Devotedly attached to the Medical Society, he was ever ready, often in a voice quivering with emotion, to take battle in matters concerning its interests; and he was a formidable opponent in debate.

On March 7, 1907, a complimentary dinner was given for Dr. Thompson, with presentation of a loving cup, on the fiftieth anniversary of his graduation in medicine; and on March 14, 1917, soon after his death, a memorial meeting was held in his honor.

Besides his son-in-law Dr. Thomas E. McArdle, several relatives of Dr. J. Ford Thompson have been noteworthy physicians in Washington. His brother, Benedict Thompson (1843–1875), was a physician of recognized ability and outspoken forcefulness, whose promising career was prematurely cut short; he (Benedict) was father of the late Dr. J. Lawn Thompson, Sr. (1874–1946), who left two sons who are physicians now located in Washington, Dr. J. Lawn Thompson, Jr. and Dr. Charles Waters Thompson.

John B. Nichols, M.D.

MEDICAL ANNALS
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VOLUME XVI *September, 1947* NUMBER 9

CLINICAL ASPECTS OF MALARIA

PAUL R. WILNER, M.D.
Instructor in Clinical Medicine, Georgetown University School of Medicine

ALTHOUGH malaria is one of the most common major diseases in the world, Washington clinicians have paid it little attention. This is completely understandable. Malaria is a rare disease in Washington. No new endemic cases have been reported here for years; but an epidemic of transmission malaria was experienced at the Gallinger Municipal Hospital in narcotic addicts using syringes.[1] Recently, however, substantial attention and even some publicity have been given to the so-called new threat of malaria because of the return of large numbers of veterans from malarious Pacific and Mediterranean theatres. Some of the possible and probably postwar malaria problems worth considering are listed in table 1.

TABLE 1
Postwar Malaria Problems

Possibility of spread by mosquitoes locally.
Transmission of malaria through blood transfusions.
Failure to recognize falciparum type which can be fatal if untreated.
Transmitted by needles of drug addicts.
Possibility of false positive Wassermann due to malaria.
Delayed primary attack (vivax).
Clinical relapses (vivax or quartan malaria).

For the propagation of malaria three factors are necessary: a host, a susceptible populace, and the transmitting vector, an Anopheles mosquito. In Washington the A. quadrimaculatus is the vector. However, mosquito control is very adequate. Although there are isolated areas in and around the city which must be carefully inspected for breeding places, our population lives for the most part in screened homes and apartment houses. There is a possibility of small localized family or community outbreaks if an infected person and family live near breeding places in the summer or mosquito months. However, no large spread of the disease can be anticipated.

The other postwar malaria problems except for the problem of clinical relapses are probably of limited interest but are worth keeping in mind.

Our interest, therefore, is concerned primarily with infected veterans of the Mediterranean and Pacific areas. In addition to returned service personnel, the Red Cross workers, UNNRA, USO, newspaper, governmental, OSS, and advisory personnel who traveled in malarious areas and make Washington their home must be considered. With resumption and expansion of world travel civilians will likewise be exposed to malaria to a greater degree than was true prior to World War II. Air travel allows return to this country from the tropics well within the incubation period of malaria.

Of the three significant types of malaria, only two are relatively common, benign tertian, caused by the Plasmodium vivax, and malignant tertian, caused by the Plasmodium falciparum. Quartan malaria is rare.

Falciparum is by far the most serious type of malaria and produces most of the mortality. When treated, it fortunately relapses only rarely, and can be permanently cured more readily.

TABLE 2

Causes of Malaria Relapse

Natural tendency of malaria to relapse.
Any infectious disease (i.e., common cold, pneumonia, etc.).
Exposure to cold—getting chilled.
Alcoholic intoxication.
Injection of adrenalin.
Injection of substance causing chill (i.e., typhoid vaccine).
Trauma—gross external or operative.
Pregnancy.

Vivax malaria is most prevalent, and it relapses commonly. It is generally the rule rather than the exception for vivax malaria to relapse. The most frequent causes of malaria relapses are listed in table 2. The disease usually burns itself out in 2 or 3 years after 2 or a dozen or more relapses, but many years may intervene before symptoms become evident or recur. Months or even years later, following suppressive therapy of individuals while in malarial areas, delayed primary attacks may occur without any history of an acute attack. Relapses and delayed primary attacks depend upon many factors, including the species and strain of the parasite, the intensity of the original infection, the immune response, and the type and amount of therapy.

Having eliminated new acute cases and falciparum cases, our problem therefore is resolved to an even more narrow sphere, to those veterans and civilians of the Pacific, Mediterranean and other malarious areas, now residing in the District of Columbia, who may have either delayed vivax primary attacks or vivax relapses. With the passage of time and the treatment of those patients who present symptoms the number of cases will gradually diminish. The recognition of this disease is important to every field of medicine. Malaria is a truly protean disease. The parasites may localize in the reticuloendothelial system and vascular system in all or any of the parts of the body. Delayed primary attacks and relapsing cases are even more confusing and vague in their manifestations than atypical acute attacks.

The varied nature of the syndrome in delayed primary and relapsing cases may bring a patient to any specialist with primary symptoms in most specialty fields. A few examples will illustrate this point: To the ophthalmologist may go the patient complaining of ocular burning, postorbital pain or conjunctival injection; the otolaryngologist may see epistaxis and headaches; the dermatologist, urticaria, purpura and herpes; the orthopedist, back and generalized pains; the neurologist, headache and cranial nerve involvement; the psychiatrist, many types of fatigue and anxiety states; the urologist, frequency and dysuria; the surgeon, suspected acute abdomens; the pathologist, the question of transfusions and false positive serologic reactions for syphilis; and the internist, a gamut of symptoms, respiratory, cardiac, gastrointestinal and general in nature.

Since cold, trauma, anesthesia, alcoholism, surgery and infections may overthrow the host-parasite immunologic relationship, the resulting manifestations of malaria may be extremely varied. A case of bronchitis, tonsillitis or pneumonia may continue longer than expected; or during the course of such a disease the temperature may rise and a complicating infection be simulated. After a surgical procedure, a phlebitis, peritonitis or abscess may be suspected to explain an unexpected fever.

If the patient has been in a malarious area, whether or not he gives a history of malaria, malaria smears must be studied. This should be routine in obscure fevers. The use of suppressive therapy may be considered whenever a breakthrough of clinical malaria may be anticipated.

In a series of 50 consecutive acute cases seen in an Army hospital in the Mediterranean area in August, 1943, symptoms were noted as follows[2]:

	Per cent
Fever at some time	100
Headache and backache	100
Chill or chilliness	64
Herpes	40
Coma	2.0
Anemia	1.5
Jaundice	1.0

The admission diagnoses were often dysentery, nasopharyngitis, bronchitis, or tonsillitis. These diseases may have been coincidental, or the symptoms may have been manifestations of malaria. The typical case of acute malaria is comparatively easy to diagnose. The symptoms are usually more varied and less specific with delayed and relapsing attacks.

Noehren,[3] refuting the classic belief of the malaria triad of periodic chills with fever, splenomegaly and anemia, made a study of 147 cases of both primary and relapsing malaria and found:

	Per cent
Anemia	33
Splenomegaly	27.7
Periodic chills and fever	6.34

He believes that we are now diagnosing malaria earlier, in the prodromal stages before the classic triad becomes evident in either acute or relapsing cases. He also noted these symptoms:

	Per cent
Headache	73
Malaise	71
Anorexia	44
Backache	32.4
Foul perspiration	26.6
Respiratory	23.6
Hepatomegaly	11.9
Vomiting	9.2
Kahn test, positive	3.3

Gordon and others[4] analyzed 435 relapsing cases and found:

	Per cent
Malaise and weakness	97
Headaches	96
General aches	88
Backache	88
Nausea	59
Vomiting	36

In a series of several thousand chronic patients Tumulty, Nichols, Singewald and Lidz[5] noted the following:

	Per cent
Weakness	94
Intolerance to heat	92
Tension	78
Exertional dyspnea	65
Anorexia	45
Insomnia	45
Blackout and palpitation	40

The adjustment of the individual to the stresses of illness and to concurrent situational factors contributed to the development, perpetuation and intensification of the symptoms in their cases.

Most and Hayman[6] believe that delayed primary attacks will produce most of the difficulty in diagnosis. They emphasize cases of fevers of undetermined origin; acute abdominal syndromes with combinations of diffuse tenderness, nausea, vomiting, pain, diarrhea and jaundice; upper respiratory symptoms with chest pain, fever, râles and chills; and neurologic groups, particularly those with underlying brain diseases or epilepsy.

There is a definite hazard of inoculating patients with malaria during transfusions. It has been recommended[7] that anyone who has had an attack of malaria or an undiagnosed fever should be free of any attacks without suppressive therapy for 2 years and have a negative smear before being used as a donor, and that anyone who has been in a malarious area should have a lapse of 1 year without suppressive therapy and a negative smear before being accepted as a donor.

The diagnosis is facilitated by thinking of malaria and searching for the parasites in any of the above-mentioned instances, particularly when the diagnosis is obscure. The history of having had malaria or a febrile illness while in a malarious area is important, but a negative history in one who has been in such a locale does not eliminate the diagnosis.

Carney and Levin,[8] in a study of Italian prisoners of war, found that 59 per cent of those with active malaria gave no previous history and 83 per cent of those with positive smears gave no history of an acute attack. In March of 1944, a non-malarious month, 26 per cent of 50 cases were without a history of a preceding attack.[2] All of these patients had taken atabrine prophylactically the preceding summer, but many took it irregularly. These were, therefore, cases of delayed primary malaria. A history of an undiagnosed fever or bouts of fever erroneously diagnosed are suggestive.

On physical examination, weight loss and fever are important. Splenomegaly is common. Of 161 relapse cases in February, March and April of 1944, 107 had a palpable spleen, usually 1 to 3 fingerbreadths below the costal margin on inspiration.[2]

A moderate anemia is usual. Rarely, however, does the red count go below 3.8. The white blood cell count is practically always low or normal with a rise in the differential of the lymphocytes.

An accurate diagnosis can be made only by demonstrating the parasite. There is a much greater chance of finding parasites with a thick smear than with a thin smear. Smears are best taken several times a day without regard for a suspected chill. Practically, the percentage of positive smears is no higher before a chill; and in the delayed types of primary and relapsing cases, with which we are now concerned, the typical chill is usually absent. In 1943, in proven cases of malaria, the positive smear was obtained on the fourth attempt, as an average.[2] Later, as experience increased, this average was reduced. The point is: 1 negative smear does not eliminate malaria in the diagnosis.

The complement fixation test for malaria using the P. knowlesi antigen gives highly specific results. Dulaney, Stratman-Thomas and Warr[9] found it positive in 81.6 per cent of patients with positive smears. While it cannot be recommended as a procedure to supplant blood film examination, it has proven to be very useful as a supplementary test. Investigations are now beng carried out to determine the practical usefulness of the test.

The treatment of malaria is both general and specific. These remarks will be limited to the specific methods of treatment. The drugs concerned are quinine and totaquine (which contains 70 per cent of cinchona alkaloids), atabrine, paludrine, plasmochin, pentaquine, and chloroquine. On several occasions in a particular study the arsenicals were used intravenously with various combinations of quinine and atabrine with no change in the duration of the acute attack or in the relapse rate. Quinine dihydrochloride intavenously is generally used on cerebral patients and is effective. However, quinine is the poorest of the drugs. There is a longer period of fever, less control of parasitemia, and a smaller relapse interval. Totaquine is similar and more toxic. Atabrine is more effective than quinine. The relapse interval is twice as long, and it cures falciparum malaria by continuous treatment of 3 weeks. Atabrine requires a high plasma concentration, stains the skin, and may be toxic, producing cutaneous and nervous system complications.

Paludrine has a wide range of activity and is cheap but has no advantage over chloroquine. The duration of treatment is 7 days in vivax and 14 days in falciparum malaria, compared with 4 days for chloroquine therapy.

Plasmochin or pamaquine may have some activity on asexual forms and is known as a gametocide. It is slowly excreted and may exhibit cumulative toxicity, particularly acute hemolytic crises in the Negro race. When given, the patient should be hospitalized. There is new evidence that its simultaneous use with quinine for fourteen days will effectively lower the relapse rate of vivax malaria.

Pentaquine is closely related to plasmochin and is effective against the exo-erythrocytic cycle of the parasite. It is more active than either quinine or plasmochin and is highly effective in reducing the relapse rate of vivax malaria when administered with quinine. However, its toxicity is too great at the present time to warrant its use in prophylaxis or prolonged suppression of malaria.[10]

Chloroquine is the drug of choice in the treatment of malaria. Quoting from Most, London, Kane, Lavietes, Schroeder, and Hayman[11]: "1. Chloroquine (SN 7618) is a highly effective, safe antimalarial drug which is superior to quinine and quinacrine hydrochloride in the treatment of the acute attack of vivax malaria for the following reasons:

- (a) Prompter control of fever in delayed primary attacks of infections of Pacific origin and in relapses of infections of Mediterranean or Pacific origin.
- (b) More rapid disappearance of parasites from the blood.
- (c) More effective, prompter control of symptoms.
- (d) Longer interval before relapse and the almost complete abolition of relapses after a short remission.
- (e) Absence of disturbing symptoms of cinchonism, and freedom from danger of inducing eczematoid dermatitis or a typical lichen planus which is due to the administration of quinacrine hydrochloride.
- (f) Ease of administration in short term courses of 1- or 4-day schedules of treatment.

"2. It is suggested that the acute attack of vivax malaria be treated routinely as follows:

"One tablet (0.3 Gm.) of chloroquine is to be administered when the diagnosis of vivax malaria is established by a positive blood smear. This amount of the drug (0.3 Gm.) is to be repeated 4 hours after the first dose. One tablet (0.3 Gm.) is then to be given on each of the following 3 mornings. The total dose is 5 tablets totaling 1.5 Gm. of chloroquine administered during 4 days."

Chloroquine is manufactured by the Winthrop Chemical Company and will be marketed under the trade name of Aralen.[12] The recommended total dosage is 1.5 Gm. of the base. Each tablet of Aralen contains 0.15 Gm. of the base. Therefore, 10 tablets of Aralen are required for the total dosage. This drug will soon be available for general use.

SUMMARY

Malaria will be seen in Washington.

It will be seen in infected veterans of the Mediterranean and Pacific areas.

It will be of the vivax type and will be relapsing and delayed and primary in nature.

The diagnosis may be confused and should always be considered in any case of febrile illness or vague groups of symptoms in one who has been in a malarious area.

Caution should be exercised in considering such people as donors.

The complement fixation test may be of great value in diagnosis.

A new antimalarious drug, chloroquine, offers great hope in the treatment of all types of cases.

BIBLIOGRAPHY

1. Personal communication from Dr. Hugh H. Hussey, Associate Clinical Professor of Medicine, Georgetown University School of Medicine.
2. Personal observations, 7th Station Hospital, Mediterranean Theatre, 1942–45.
3. Noehren, T. H.: Ann. Int. Med., 1946, **25**, 293.
4. Gordon, H. H., and others: Arch. Int. Med., 1945, **75**, 159.
5. Tumulty, P. A., Nichols, E., Singewald, M. L., and Lidz, T.: Medicine, 1946, **25**, 17.
6. Most, H., and Hayman, J. M., Jr.: J. A. M. A., 1946, **130**, 480.

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A REVIEW OF SOME OF THE ADVANCES IN OPHTHALMIC SURGERY DURING WORLD WAR II*

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IMPORTANT advances were made in ophthalmic surgery during World War II, and today I shall discuss a few of the newer surgical approaches to some of the more difficult ophthalmic problems. I have chosen those procedures which are quite as applicable to civilian practice as they were useful in Army hospitals.

The subjects chosen for discussion are: (1) radical treatment of recurrent pterygia, (2) the use of fascia lata transplants for correction of sinking or retraction of the upper lid after enucleation, and (3) the use of buccal mucosal grafts in ophthalmic surgery.

PTERYGIUM

The importance of recurrent pterygium was emphasized by the large number of patients with this condition who finally reached one of the special eye centers established by the Army during the recent War. One patient who was admitted to Valley Forge General Hospital had had 13 previous operations for pterygium on one eye. In such cases as his it was evident that the operative procedures employed were not only failing to effect a cure, but also were adding to the disability of the patient and producing distressing cosmetic blemishes. Buccal mucosa has been advocated as a substitute for conjunctiva lost in extensive resections of pterygia. The objection to buccal mucosa on exposed surfaces of the globe is that it retains its decidedly pink color after being transplanted. In some of the cases which will be discussed later the transplanted mucous membrane had been carried onto the cornea by recurrent growth of the pterygium.

Spaeth[1] has cited "a case in which a pterygium had been operated upon 3 times, twice by McReynold's transplants following an initial resection. It was easily corrected with a mucous membrane graft." Before this procedure, the eyeball was fixed in a state of symblepharon due to loss of conjunctiva. In several cases we treated, the procedure outlined by Spaeth had already been carried out.

As long ago as 1809 Scarpa[2] recommended the destruction of vessels leading to a nebulous corneal scar. He pointed out that simple sectioning of the vessels was insufficient to prevent proliferation, and he advised the removal of a circumcorneal strip of conjunctiva as a means of interrupting corneal vascularization.

In 1909 Wiener[3] described his method of performing lamellar corneal resection. Later (1931) Hilgartner and Hilgartner[4] reported cases operated upon by this method, but with the addition of radium treatment following the corneal resection in an attempt to prevent further vascularization.

James,[5] in describing his technic for the surgical removal of corneal scars, suggests that "on the third postoperative day, if new vessels are seen in the cornea, the eye should receive a light X-ray exposure. This should be repeated on the sixth and ninth postoperative days."

Castroviejo[6] devised another method of treating recurrent pterygia by partial superficial keratectomy and graft of buccal mucous membrane. According to his technic, the superficial layers of the cornea, including the apex of the pterygium, are dissected free. When the limbus is reached, the conjunctiva is undermined with the aid of scissors. The edge of the pterygium is excised along with the excess of connective tissue. The defect left on the eyeball is then covered with a graft of buccal mucosa. The postoperative treatment consists of exposure to X-ray beginning not later than 24 hours after the operation to prevent recurrence of corneal vascularization.

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* Read at the Twenty-eighth Annual Meeting of the Virginia Society of Ophthalmology and Otolaryngology, held at the Cavalier Hotel, Virginia Beach, Va., May 10, 1947.

The many recurrent cases of pterygium which came to our attention at Valley Forge stimulated our efforts to evolve a technic which would decrease or eliminate the possibilities of recurrence. The procedure which we worked out gave most encouraging results and has proved to be equally efficacious in civilian practice.

The superficial layers of the cornea, including the entire area involved by the pterygium, are dissected to the limbus. The dissection should be carried deep enough to remove all of the corneal stroma rendered opaque by recurrences of the pterygium. When the limbus is reached the dissection is continued on to the sclera in essentially the same plane for a distance of 5 mm., care being taken not to disturb the insertion of the rectus muscles. If possible, all connective tissue should be removed from the sclera without penetrating deeper than its superficial layers. The head of the pterygium, including the corneal layers, is now excised, and the fibrous connective tissue is dissected free from the overlying conjunctiva. The conjunctiva is sutured to the episclera 4 mm. from the limbus. Atropine and penicillin ointment are instilled and a sterile dressing applied. Within 24 hours after operation the eye receives X-ray treatment, which is repeated on alternate days during the first week until a total of 400 r has been given. This is similar to the dosage recommended by Castroviejo.

The denuded sclera lying between the conjunctiva and the limbus becomes epithelialized fairly rapidly, but when postoperative X-ray therapy is employed there is little tendency for the area to become vascularized. The use of Beta irradiation is probably more desirable, since there is less danger of producing radiation cataract. However, no lenticular disturbance was noted in any of our patients treated with X-ray. The following are illustrative cases.

Case 1. In 1941, a soldier, aged 23, on overseas duty, first noticed a growth developing on the nasal side of his left eye. It increased in size, and in July, 1943 he was hospitalized with a diagnosis of pterygium. The growth was removed. It soon recurred, and a second operation was performed in September. The pterygium again recurred, and a third operation was performed in December. The patient was returned to a hospital in the United States, where a fourth operation was performed in March, 1944. The procedure consisted of excision of the pterygium, followed by a transplant of mucous membrane from the mouth to cover the denuded sclera.

In July, 1944 the patient was admitted to Valley Forge General Hospital, where examination revealed the nasal one third of the cornea to be covered by a growth which was very vascular, elevated and pink. There was little infiltration of the cornea beyond the growth itself.

Partial keratectomy was performed, leaving almost the entire nasal half of the left cornea quite transparent. The dissection was carried beyond the limbus on to the sclera, going back as far as the insertion of the medial rectus to remove a greatly thickened fibrous connective tissue layer from the subconjunctiva and episcleral area. This dissection was carried on to the sclera from "7 to 10 o'clock." The portion of the pterygium which had involved the cornea and the connective tissue layer was excised. The margin of the remaining conjunctiva was anchored to the episclera throughout the extent of the dissection with interrupted silk sutures, at a distance of 4 mm. from the limbus. Fractional doses of X-rays, 100 r at each exposure, were given, beginning within 24 hours after operation and continuing until 400 r had been given within 1 week.

Case 2. A soldier 25 years of age had developed a pterygium on the nasal side of the right eye, and operation was performed in September, 1942. A second operation was performed about 3 weeks later at the same hospital and a third in December. Following this series of operations, external rotation of the right eye was limited to such an extent that diplopia was constantly present on looking to the right. In September, 1943 the pterygium was excised and a buccal mucosal graft was utilized to cover the denuded area. Vision became progressively more blurred following this procedure.

Examination on admission to Valley Forge General Hospital revealed the vision in each eye corrected to 20/20. In the right eye there was an extensive pinkish, elevated mass, overriding the cornea from "1 o'clock to 6 o'clock," extending onto the cornea for a distance of 5 mm. and back toward the inner canthus for a distance of 1.5 cm. It continued below the limbus at "5:30 o'clock."

Slit lamp examination revealed a thin, gray line of infiltration 2 to 3 mm. wide in the superficial layers of the cornea distal to the margin of the pterygium. Numerous, fine vascular loops could be seen beneath the surface of the mass.

On March 29, 1944 the following operative procedure was carried out. The pterygium and the superficial layers of the cornea were dissected free to the limbus, leaving the deeper layers of the cornea transparent. The dissection was carried beneath the fibrous connective tissue which lay between the graft and the sclera, thus separating the growth, which was then excised. The dense fibrous connective tissue beneath the mucous membrane was removed, and the conjunctiva was sutured to the sclera about 4 mm. from the limbus. The postoperative treatment consisted of fractional doses of X-rays, as outlined by Castroviejo.

All patients so treated were kept under observation for several weeks until it could be determined that there was no tendency toward recurrence of the pterygia. After these patients were discharged to duty, an effort was made to have them assigned within the area served by the hospital. Not one of them was returned for treatment because of recurrence.

RETRACTION OF THE UPPER LID AFTER ENUCLEATION

Another condition which produces a distressing cosmetic blemish is the sinking of the orbital contents posterior to the septum orbitale following enucleation. This sinking or retraction of the upper lid, if it does occur, usually takes place within a period of months after enucleation.

A number of ophthalmic surgeons have reported operative procedures they have employed to correct this defect. Among them is Spaeth,[7] who has described a technic for the utilization of fascia and muscle. He states, "Dissection is carried backward into the depth of the orbit and along the entire line of the upper lid toward the nose." He advises the employment of "scales of cartilage" if the defect is extensive.

DeVoe[8] recommends the use of dermal grafts for the correction of this deformity. He implants 2 layers of skin from the back, high and superficially beneath the skin of the upper lid. He draws attention to the fact that there is some absorption of this dermal tissue. An important point, brought out by Pfeiffer[9] and emphasized by DeVoe, is that what may appear to be atrophy of orbital tissues may be a consequence of fracture of the orbital floor, so often encountered in war injuries.

Cutler[10] has pointed out that material placed behind the septum orbitale has a tendency to disappear into the orbit where it may interfere with the action of the levator. It was his experience that the fascia must be placed beneath the orbicularis; otherwise it will adhere to the skin with resultant induration and scar tissue formation. Therefore, it is imperative that the implanted material be inserted between the orbicularis and the septum orbitale.

The operative procedure outlined by Cutler is ingenious but not difficult, and the end result is extremely satisfactory. He employs fascia lata procured from the lateral aspect of the thigh; the tissue is placed in normal saline solution until the lid has been made ready to receive it. Cutler describes his operative technic in detail in the February 1946 issue of the *American Journal of Ophthalmology*. The operative measure he employs can be strongly recommended for restoring the normal upper lid fold when a depression exists after enucleation.

Case 3. A woman, 55 years of age, had had an enucleation of the right eye on March 6, 1946 because of absolute glaucoma. A gold sphere, 16 mm. in diameter, was implanted in Tenon's capsule at the time of enucleation. The patient made an uneventful recovery and was able to wear an adequate prosthesis. By August a marked depression over the right upper lid had developed, producing a rather marked cosmetic blemish. A fascia lata transplant from the right thigh to the right upper lid was performed on January 9, 1947, following the technic as outlined by Cutler. The depression was filled in, the deformity thus being eliminated.

USE OF BUCCAL MUCOSAL GRAFTS

Mucous membrane grafts became much more widely used in ophthalmic surgery during the War. They were employed with great success in certain conditions in which their practicability had been deprecated by some ophthalmic surgeons; for example, in the opening paragraph of the section of his book dealing with mucous membrane grafts, Spaeth[11] makes the following statement: "There is only one defect for which these grafts are to be used, and that is for the correction of conjunctival defects with an intact eyeball."

In discussing restoration of the cul de sac, Berens[12] states that "instead of the Wolfe graft, mucous membrane from the lip or inner surface of the cheek or the conjunctiva of a rabbit may be used." Heterogeneous grafts have proved to be altogether unsatisfactory and therefore have been abandoned.

In the recent War there were many cases in which there was loss of an eye with either partial or complete obliteration of the orbital socket. Where attempts were made to repair such defects with skin in the presence of some normal conjunctiva, marked secretion and a most disagreeable odor resulted. These undesirable features made it necessary to remove partial restorations of the socket which consisted of skin.

In my experience the most satisfactory method of repairing either partially or completely obliterated sockets is with buccal mucosa. Complete restoration of an orbital socket can be effected by taking a mucosal graft from the inside of each cheek. This procedure is carried out in 2 stages, the cul de sac and a portion of the floor of the socket being restored at each stage. As advocated by Wheeler,[13] the dissection of the socket is performed first, care being taken to carry the dissection well into the fornices and to undermine both the caruncle, medially, and the outer canthus. It is most important to remove all scar tissue in the field of dissection. A full thickness graft is cut from the buccal mucosa; all the submucosal tissue is removed, which leaves it as thin as possible without perforating. The graft is placed in position and secured by interrupted sutures of 7-0 silk. After this is completed, either 2 or 3 mattress sutures of heavier silk are threaded through soft rubber plates and then passed through the graft in the fornix, then through the periostium of the orbital margin, and finally brought out on the skin surface of the cheek or brow. Here they are again passed through rubber plates to prevent their cutting into the skin and are tied. The socket is packed firmly with vaseline gauze, and a pressure dressing is applied.

It has been found that uniform pressure can be far more effectively obtained by packing with vaseline gauze than by the use of a stent. By packing the socket firmly the graft is made to spread out more evenly, and thus there is more complete and uniform contact between the raw surfaces than could be obtained otherwise.

The firm pressure dressing is left in position for a period of from 5 to 7 days. At the end of that time the packing is removed; then the socket is repacked firmly and a pressure dressing reapplied. The dressing is changed every third day until 2 weeks after operation. By the end of this time, the graft is well healed, and surgical treatment may be continued if necessary.

As soon as healing is complete, an acrylic form or an artificial eye should be placed in the socket to maintain its shape. There is some tendency for shrinkage of the graft, but it is slight and can easily be allowed for at the time of operation.

Just as skin remains skin, regardless of where it may be, so buccal mucosa retains its characteristics in the orbital socket. It remains much pinker than normal conjunctiva and secretes a slightly more tenacious mucus. However, it furnishes an excellent substitute for conjunctiva in cases in which the eye has been removed with resultant contraction of the socket.

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THE USE OF PARENTERAL FLUIDS IN THE TREATMENT OF SHOCK*

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THE treatment of shock with blood, plasma and other fluids is based upon an understanding of the circulatory changes which are peculiar to shock. The present knowledge is a result of the close correspondence of the circulatory changes in animal experimental shock and the changes in human shock, and of the application of these findings and results to clinical cases. The modern therapy of shock is directed toward the interruption of the pathophysiologic circulatory cycle by the correction of oligemia with an agent that increases the total circulating blood volume and the total circulating osmotic pressure.

There is definite agreement that the most important initiating factor of the pathologic physiology of shock is a reduction in circulatory volume. In a given case, the reduced blood volume is caused by one or more, or all, of the following factors:

1. Local loss of fluid, internal or external (plasma, plasma and blood)

Clinical examples: Burns, mechanical trauma, freezing, surgical procedures, intestinal obstruction, peritonitis, crushing injuries, thrombosis, gangrene, strangulated hernia, and mesenteric thrombosis.

2. Loss of blood, visible and invisible

Clinical examples: Ruptured organs, ruptured or torn blood vessels, mechanical trauma, postpartum hemorrhage, ectopic pregnancy, bleeding peptic ulcer, esophageal varix, gastric carcinoma, rectal polyp, rectal carcinoma, crushing injuries, ruptured aneurysm, and hemorrhagic diathesis.

3. Toxic agents or factors (histamine or histamine-like substances)

Clinical examples: Peritonitis of chemical or bacterial origin, wound infection, gas bacillus infection, burns, crush syndrome, hemolytic transfusion reactions, gangrene, and anaphylactic shock.

4. Nociceptive impulses

Clinical examples: Mechanical trauma (fractures; rough transportation; surgical procedures on periosteum, mesentery, peritoneum, large blood vessels, peripheral nerves, pleura and sympathetic nerves; and pain after surgical procedures).

Since the original studies on the wounded during World War I, it has been repeatedly shown, both experimentally and clinically, that relative or absolute oligemia is practically always present in secondary shock. Evans[1] and his group found a 15 to 20 per cent reduction in blood volume before signs of severe shock, and a 38 per cent blood loss as the average in cases of severe traumatic shock. A 25 per cent diminution in blood volume is necessary, in a previously healthy individual, before secondary shock becomes evident clinically. The relationship of hemorrhage to the development of secondary shock in trauma is important. Two factors influence the development of shock with hemorrhage. The first is the amount and rate of blood loss. The second is the ability of the reserves of blood and body fluid to compensate for the reduced blood volume.

Hemorrhage of an amount too small to alter materially the blood volume, cardiac output and venous return, and for which the body mechanisms compensate for the lost blood volume, does not lead to secondary shock. The loss of 500 c.c. of blood in a previously healthy individual causes no significant clinical changes. We are all accustomed to the fact that a healthy donor can give 500 c.c. of blood and can rise from the table and go about his customary activities without any serious consequences. In a recent study of the effect of bleeding a group of donors 500 c.c., roughly 10 per cent of the circulating volume, or 2.5 to 3.8 c.c. per pound of body weight, Shenkin et al[2] noted:

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"An average decline of the systolic pressure of 13 mm. in the supine position and 14 mm. Hg in the standing. Diastolic showed no significant change in the supine, but a 7 mm. of mercury drop in the standing.

"The pulse rate did not change when in the supine, but in the erect it increased 36 per cent in 1 hour and 1 hour later to 40 per cent.

"The cardiac output and stroke volume changed very little in the supine position."

These authors also noted that the loss of 1,000 c.c. produced early clinical manifestations of shock if such factors as activity, fear, etc. were added.

It is common practice to minimize the amount of blood lost in trauma and surgery. For example, in the following operations, in the hands of good surgeons, one can expect these blood losses:

Gall bladder	300–500 c.c.
Gastrectomy	800–1,000 c.c.
Radical mastectomy	800–1,000 c.c.
Thoracoplasty	700–1,000 c.c.
Pneumonectomy	1,000–1,500 c.c.

In a study of blood changes during major surgical procedures, I have found that the hemoglobin and red blood cell count decreased 25 per cent or more after gastric resection and subsequent hemodilution.

To treat a case of secondary shock, one must be fortified with the knowledge of the amounts of blood and plasma lost, and with the associated contributing factors present. The following list summarizes the associated conditions which may be present with reduced blood volume:

- Dehydration
  - inadequate intake
  - excessive loss
  - excessive utilization
  - abnormal utilization and storage
- Hypoproteinemia
- Anemia
- Glandular hypo- or hyperfunction (adrenal, thyroid, pituitary)
- Salt deficiencies
- Abnormal acid-base balance-acidosis or alkalosis
- Decreased oxygen consumption
- Anesthesia
  - General-hypoxia and acidosis
  - Spinal-decreased circulating volume
  - Specific drugs-barbiturates (toxic to respiratory center)
- Excessive cold
- Excessive heat
- Exhaustion
- Mechanical irritation or trauma
- Sensitivity to medication
- Fear
- Pain
- Extremes of age
- Debilitating diseases
- Diabetes mellitus
- Inanition
- Vitamin deficiencies

Clinical cases of shock are treated according to the severity of the injury, the degree of blood loss, the degree of shock as manifested clinically, and the duration of the shock.

In my experience, the initial dose of blood or plasma for various degrees of shock is:

Mild shock	300–500 c.c.
Moderate shock	500–1,000 c.c.
Severe shock	1,000–1,500 c.c.
Profound shock	1,500–2,000 c.c.

In a given case of shock it may be necessary to give 3, 4, 6 or even 10 liters of blood or plasma. I know of a case of hemorrhagic shock that received more than 25,000 c.c. of blood and plasma, and the patient subsequently recovered. It must be emphasized that large amounts of blood or plasma are required for the successful treatment of secondary shock, particularly in those cases which develop shock after severe traumatic injuries, such as casualties in modern warfare.

No hard and fast rule can be made to govern the dosage for all cases, because the variations in shock cases are too numerous. Each patient must be treated individually and observed throughout the treatment period to determine the response and further needs.

The principle underlying the use of blood or plasma for shock is the early, rapid injection of large amounts, which are repeated as is needed.

It has long been the custom regardless of the stature of the patient or the degree of shock to arbitrarily transfuse 250–500 c.c. of blood or plasma, possibly because the original unit of plasma was 250 c.c. and the usual amount of blood which is withdrawn from a donor is 500 c.c. These impaired quantities have no clinical significance. In fact, this arbitrary idea of dosage has no doubt caused the death of patients for whom larger amounts were needed but were empirically withheld. The experiences of World War II have dispelled the 500 c.c. dose idea, and now larger, more nearly optimal amounts of blood, plasma, or serum are given. It is better to err on the side of "too much too early" than "too little too late."

Another point to remember for judging the dose of plasma is that an optimal dose is an amount which does not necessarily restore the total volume lost, but which does restore the body to a level of good function.

A good clinical criterion for adequate replacement therapy is the response of the patient to the transfusion. Any patient in secondary shock, having a systolic pressure below 100 mm. Hg and a pulse pressure of 25 or less, should be given enough blood or plasma to keep the systolic pressure at 100 mm. Hg or more, and the pulse pressure at 25 or more. One can anticipate a 15 to 25 mm. Hg rise in the systolic pressure with each pint of blood or plasma transfused in shock if bleeding has ceased and no other causes of loss of circulating plasma are operating. In a study of 50 consecutive cases of shock I have noted an average slowing in pulse rate of 29 per minute which occurred from an infusion of 800 c.c. of plasma.

If the initial dose does not produce the needed response, then more blood or plasma should be given. No case should be regarded as irreversible until death is imminent. There is little risk of overdosage, although I am certain that lives have been lost by underdosage. Inadequate blood or plasma therapy is wasted blood and plasma.

Numerous formulas and rules for the amount of plasma required for the treatment of shock have been developed. If hemoconcentration is present, a rough guide for the initial dose is 1,000 c.c. of plasma for every 20 or 25 per cent increase in blood cellular concentration. Another plan advocates 100 c.c. of plasma for each point of elevated hematocrit. On the basis of body surface burned, one should give at least these amounts of plasma during the first 24 hours; for 10 per cent surface burned, 1,000 c.c. of plasma; for 20 per cent surface burned, 2,000 c.c. of plasma; and for 30 per cent surface burned, 3,000 c.c. of plasma.

Little is taught or said about the rate of intravenous administration. The usual transfusion rate is 8 to 10 c.c. per minute. At this rate, an infusion of 500 c.c. will require about 1 hour. The proper rate of transfusion for shock varies with the needs, so that the greater the oligemia and the lower the total circulating osmotic proteins, the greater the rate of transfusion. The converse is also true. In severe shock it may be necessary and wise to give the optimal dose in 10 to 30 minutes. Recent experiences have impressed me with the effectiveness of rapid infusions of blood or plasma, and it is my impression that an identical amount of either blood or plasma is more effective if given rapidly than if given at the usual rate obtained by the gravity method. There are numerous technics for increasing the transfusion rate. One of the simplest and most effective is the use of a blood pressure bulb attached to the air vent of the transfusion bottle. With the screw closed, the injected air increases the pressure within the bottle and thereby the rate of flow. I have administered 500 c.c. of iso-osmotic plasma in 8 to 10 minutes by this method. The possibility and dangers of speed shock and of right-sided heart failure are minimal, and the advantages of rapid injection far exceed these possible dangers. The end-results in the management of shock will be better if large amounts are given rapidly.

A guide to the speed needed for injection is the response of the patient. If, after the rapid injection of 500 c.c. of plasma, the systolic pressure is 100 mm. Hg or above, and the pulse is beginning to decline, the infusion may be slowed to 10 to 20 c.c. per minute until the optimal response is obtained and sustained. After a good response to a rapid infusion, it will be noted that easy flow is readily maintained.

It is repeated for emphasis that the earlier shock is treated, the smaller will be the amount of plasma or blood required for a good result. Large, adequate amounts given early, rapidly, and repeatedly, are necessary for effective results.

If blood is the major element lost, then blood should be given. If plasma is the major element lost, then plasma should be given. If blood is being lost, and no compatible blood or type O blood is available, then plasma should be given to correct the shock until blood is available. Few patients die of shock as a result of a lack of red blood cells, but many die because of a decrease in blood or plasma volume. An acute reduction of 50 to 60 per cent in the red cell volume will not produce signs of anoxia or shock if the normal total circulating osmotic pressure and fluid volume are maintained with plasma or serum infusions. Nine years of experience has convinced me beyond doubt that the correction of the oligemia of hemorrhagic shock with plasma will effect a good result. I do not wish to imply that plasma is the agent of choice for hemorrhagic shock or traumatic shock with hemorrhage, but I do believe that the early, adequate administration of plasma in hemorrhagic shock or hemorrhage will prevent the development of a critical point at which the diminished blood volume will lead to a progressive tissue anoxia and irreversible shock. The possibility of irreversibility brings into sharper focus the importance of early, adequate treatment. There is a prevailing impression that plasma is not good for the treatment of traumatic shock associated with hemorrhage. If we qualify the use of plasma in such cases, the reason for this misconception becomes apparent. A hypothetical case example will help to clarify this point:

A patient admitted to a hospital in severe traumatic shock with hemorrhage is immediately given a large dose of plasma to correct the oligemia. The patient partially recovers, and there is a temporary stabilization of the circulatory system at a low optimal level. The wounds still continue to lose some blood, and surgery is indicated. At this time, a moderate to severe anemia exists, and the total blood volume has been only partially replaced. We now anesthetize the patient and operate. The anesthesia increases the anoxia, and the surgery produces a greater loss of blood. If we now give the patient plasma alone to correct the shock, we can readily see that a profound red cell deficiency will produce hypoxia that in turn will produce serious changes throughout the body. Therefore, for this type of trauma and hemorrhage with shock, one should give whole blood and not plasma. Yet plasma, given early, prevents development of deeper shock until blood is available.

A simple rule that can be followed is to give at least one half as much blood as plasma in the emergency treatment of trauma with hemorrhage and shock.

Plasma is not whole blood, therefore one cannot expect the same results. However, isoosmotic plasma or serum is the best blood derivative or substitute available at the present time.

I have made the statement that for cases in which plasma is the major factor lost, plasma should be given. There exists an impression that in burn shock only plasma is necessary. In fact, it has also been said that blood is deleterious in burn shock because it increases the hemoconcentration and therefore the stagnation of blood. Recent clinical studies have lent doubt to this theory, and it is now submitted that whole blood can be, and probably should be, given for burn shock because there is a definite destruction of red blood cells. The hemoconcentration which is noticed in the early phases of burn shock actually masks the underlying anemia. Another reason for giving blood early in burn shock is the rapid and early development of a hypochromic microcytic anemia in the stage immediately following recovery from the acute shock.

The advantage of the use of whole blood in the management and treatment of shock is that, in most cases, whole blood is lost. The major disadvantages to whole blood transfusion are:

1. An interval of time is necessary to make whole blood available for transfusion unless universal donors' blood is employed.

2. Preservation is relatively short, varying between 10 and 21 days and transportation is moderately difficult and bulky.

3. Reaction incidence with blood varies between 6 and 8 per cent, and a certain number of fatal reactions can be expected with large numbers of whole blood transfusions.

Plasma or serum are the best known blood derivatives or substitutes. These agents are effective in the management and treatment of secondary shock. The advantages of the use of plasma are:

1. It may be given without regard for type.

2. It is preserved for indefinite periods as liquid, frozen or dried.

3. It is transported easily and has little bulk.

4. The reaction incidence is less than 1 per cent, and severe reactions are practically unknown.

5. It can be given intramuscularly or subcutaneously, and can be given more rapidly than whole blood.

6. Volume for volume, plasma has a greater osmotic effect than whole blood.

Other blood and plasma substitutes have been developed. The list of these includes:

1. Acacia
2. Ascitic fluid
3. Bovine plasma and serum
4. Bovine albumin and globulin
5. Pectin
6. Fish gelatin and isinglass
7. Animal gelatin
8. Amino acid solutions or protein hydrolysates
9. Globin

Specific statements about the three most important, animal gelatin, pectin and amino acid, will be presented.

Animal gelatin is probably the best of these substitutes. Plasma proteins have a diameter close to 36 Ångström units, whereas most particles of gelatin and degraded gelatin have a value of half of this, or 18 Ångström units. Hence they tend to leave the circulatory bed rather rapidly. The largest part of the plasma proteins do not deviate greatly from the symmetrical shape, except for fibrinogen. Gelatin appears to be made of linear, polypeptide chains loosely coiled to give very large molecules. The process of degradation decreases the number of very large particles, which are responsible for much of the viscosity, and therefore decreases the colloid osmotic pressure. The optimal gelatin solution for the treatment of hemorrhage or shock is a 6 per cent concentration of gelatin in saline solution. Clinically this can be given without pyrogenic, late toxic or sensitization reactions, and both clinical and experimental studies show that it has a definite effect of augmenting cardiac output and circulatory blood volume in shock. This solution has also been found to be beneficial in burn shock. Since the effect of gelatin solutions is more fleeting than that of plasma, it is necessary to give multiple and frequent injections. Another disadvantage of the use of gelatin is that it is not a complete protein and can therefore not be utilized to restore the tissue and blood protein deficiency which frequently occur after shock. Recent studies of the combined use of gelatin and amino acids reveal encouraging results in the correction of hypoproteinemia and associated shock.

Pectin is a colloidal carbohydrate of high molecular weight and rather complex composition. It is prepared from protopectin by hydrolysis with 0.5 per cent ammonium oxalate at 70 to 90 degrees, or by heating with dilute acids. A 0.5 or 0.75 concentration in a buffered sodium chloride or Hartman's solution can be expected to give good or fair results in the prevention and treatment of shock. Pectin is excreted almost unchanged in the urine. The amount excreted in the first 8 to 12 hours is small but reaches its maximum within 24 hours, so that within 48 to 72 hours most of that injected has been eliminated. Myer and his group[3] have observed that pectin solution intravenously produces a greater degree of hemodilution in patients in shock than those not in shock. The increase in plasma volume as represented by the hemodilution speaks for the beneficial effect of pectin. However, this drug is ineffective in a number of cases where blood and plasma relieve shock. It is also known that pectin is deposited in the organs and in the phagocytic cells of the body. One may summarize the work on pectin by saying that it is not a substitute for whole blood or plasma, but that it does raise the plasma volume in shock.

Amino acids, or protein hydrolysate solutions, are used as substitutes for or supplements to acute and chronic protein deficiency therapy. In acute shock there is a loss of circulating plasma protein, particularly in the albumin fraction. A decrease in the circulating osmotic pressure follows. The use of amino acids or hydrolysates which have the same molecular size as that of crystalloids is of no immediate value in the treatment of the acute phase of shock. However, it must be remembered that a patient treated for shock is rarely given enough plasma to correct the amount lost, and therefore a deficiency ensues. In this subacute type of protein deficiency amino acids or protein hydrolysates may be used to supplant plasma or blood in rebuilding adequate tissue and plasma protein levels.

An enzymatic digest of a fraction of mammalian blood has been prepared by the Baxter Laboratories, Incorporated. This is available as a clear, light amber 5 per cent solution. In the process of preparation all toxic and undesirable constituents are removed, sterility is maintained and the end product is stable, heat sterilized, and pyrogen-free. The pH is approximately 6.5. The chemical formula for the preparation is:

	Gm. in 100 c.c. of solution
Total solids	6.0
Total nitrogen	0.625
Amino nitrogen	0.325–0.39
(50–60 per cent of the total nitrogen)	
Ammonia nitrogen	0.004–0.008
Ash	0.85

Nitrogen balance studies in dogs performed before distribution of this product prove that the end product is capable of maintaining positive nitrogen balance and growth when it is the only source of protein.

My clinical investigation of this product shows that the intravenous reaction rate is less than 1 per cent. No severe reactions or systemic reactions have occurred in 731 consecutive intravenous infusions. No local reactions such as phlebitis, etc., have ever been seen throughout the 4 years of investigation. As much as 60,000 c.c. has been given intravenously to 1 patient. The preparation may also be given subcutaneously, intramuscularly, or intrasternally, and causes no greater discomfort than would normal saline solution. As much as 23,000 c.c. has been given subcutaneously to 1 patient without any complications.

Repeated clinical studies show that the solution alone, or preferably with adequate amounts of glucose, will maintain positive nitrogen balance in preoperative and postoperative patients without markedly increasing the nitrogen loss, and that plasma proteins, particularly the albumin fraction, will be regenerated if hypoalbuminemia is present when this solution is used as the only source of protein.

In calculating the amount needed by a patient, total nitrogen of the urine and the blood albumin are considered. Studies of cases of postoperative gastric resection show that the daily nitrogen loss averages between 10 and 15 Gm. Therefore, using this as a guide, one should give 2,000 c.c. of protein hydrolysate per day, for this supplies 12.5 Gm. of nitrogen (each 1,000 c.c. contains 6.25 Gm. of nitrogen). For every Gm. per 100 c.c. of plasma that the albumin level is reduced, one should add approximately 30 Gm. of protein (or another 1,000 c.c. of protein hydrolysate) per day (6.25 Gm. of nitrogen is equal to 42.5 Gm. of protein).

The intravenous use of protein hydrolysate provides proteins which normally would enter the body by the gastrointestinal tract. Parenteral protein therapy permits better preoperative and postoperative care of surgical patients. "The operation was a success but the patient died" probably refers to many instances in which as a result of a severe hypoproteinemia the body fails to recover.

The subject of crystalloids must be discussed briefly. In shock the permeability of the capillaries is increased, and the osmotic pressure produced by the proteins, and the blood volume, are decreased. All this means that fluid and protein are lost into the extravascular spaces; therefore, the addition of crystalloid solution containing molecules of a diameter less than 20 Ångström units will produce only a temporary rise in blood volume that will result in a subsequent loss of more fluid and protein. This increases the oligemia and furthers the mechanism of shock. Best and Taylor[4] state that the intravenous injection of saline solution is of little value and may cause pulmonary edema if used in hemorrhage or shock. Blalock[5] states that sufficient fluids can be administered to correct the dehydration, but that larger quantities are apt to result in harm rather than in benefit; also, when in the course of treatment of a patient it is found that plasma protein is decreasing while the concentration of red blood cells is increasing, plasma is being lost from the blood stream and nothing is being accomplished. Dunphy and Gibson[6] found that in early experimental shock a single infusion of saline solution in an amount calculated to raise blood volume to normal not only is of purely temporary benefit but causes such a dilution of plasma protein that the late tissue changes of shock are accentuated.

It may be said that crystalloid solutions in shock are indicated for the dehydration, for maintaining postshock fluid balance, for the early phases of neurogenic shock, and for keeping a vein open until plasma or blood can be administered. Ambiguous, equivocal therapeutic results are obtained in the early stages of secondary shock; this is true in hypotension from hemorrhage and in advanced shock, after the use of plasma and blood. Also, pernicious results may follow the use of crystalloid solutions in advanced shock and in the postshock period when massive doses are used in the face of existing or developing protein deficiency or pulmonary edema.

BIBLIOGRAPHY

1. Evans, E. I.: Significance of blood volume alterations in surgical patients. South. M. J., 1945, **38**, 214.
2. Shenkin, H. A., and others: On diagnosis of hemorrhage in man; study of volunteers bled large amounts. Am. J. M. Sc., 1944, **208**, 421.
3. Meyer, K. A., Kozoll, D. D., Popper, H., and Steigmann, F.: Pectin solutions in treatment of shock. Surg., Gynec. & Obst., 1944, **78**, 327.
4. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, 2nd ed. Baltimore: Wood, 1939.
5. Blalock, A.: Principles of Surgical Care, Shock and Other Problems. St. Louis: Mosby, 1940.
6. Dunphy, J. E., and Gibson, J. G., Jr.: Effect of replacement therapy in experimental shock. Surgery, 1941, **10**, 108.

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RADICAL PANCREATICODUODENECTOMY FOR CARCINOMA OF THE AMPULLA OF VATER AND HEAD OF THE PANCREAS

Report of a Case

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WE ARE presenting a case in which a radical pancreaticoduodenectomy was performed for carcinoma of the ampulla of Vater and of the head of the pancreas. At this writing, 18 months after the operation, the patient is living and unusually well. Patients who have had successful radical pancreaticoduodenectomy are still sufficiently few to justify presentation. We believe that this patient is the longest survival in this city. In 1940 Whipple[1] performed the first radical 1-stage pancreaticoduodenectomy. In July 1945 Orr[2] collected 104 cases of radical pancreaticoduodenectomies, which were all of those reported up to that time. Undoubtedly there are many unreported cases. Our patient is made more interesting because she had cholelithiasis and common bile duct stones in addition to carcinoma of the pancreas.

REPORT OF CASE

S. J., a white woman of 69 years, developed generalized weakness and constipation early in January, 1946. A mild jaundice followed which was intermittent at first but became persistent and progressive after a few weeks. She had attacks of intermittent pain in both lower quadrants of the abdomen with the onset of jaundice, but these pains did not persist and eventually she had a painless jaundice. There was no pain in the epigastrium, upper right abdominal quadrant, or in the scapular regions. Her stools became clay-colored, and her urine was very dark and foamy. There was no pruritus. She lost 10 pounds in a period of 6 weeks, notwithstanding a "good appetite."

Her past history revealed no attacks of jaundice or upper abdominal pain. She had had no operations other than a tonsillectomy. She had had 8 pregnancies and had 3 living children. She passed through an uneventful menopause at the age of 42 years. In recent years she had had a mild arthritis of the hands.

The patient was a well-developed, thin, elderly, intensely jaundiced woman in no acute distress. Her head and chest were negative. The liver was smooth with round edges and enlarged to 3 fingerbreadths below the right costal margin. There was no ascites and no abdominal masses. Her pelvis was negative.

A Graham-Cole gall bladder study was made. No dye was taken up or concentrated by the gall bladder. A nonfunctioning gall bladder with obstructive jaundice was reported. A gastrointestinal roentgenologic study showed a small diaphragmatic hernia and the enlarged liver. There was no deformity of the duodenal arch and no evidence of pathology. On admission she had 74 per cent hemoglobin, 3,840,000 erythrocytes and 10,000 white blood cells per cu. mm., with 84 per cent polymorphonuclear leukocytes and 12 per cent lymphocytes. The urine showed a trace of albumin and was strongly positive for bile. Microscopic examination of the urine revealed a few uric acid crystals and a few white and red blood cells. The stools were negative for bile. The icterus index was 57 units. The Van den Bergh was immediate direct with an indirect reading of 10.5 mg. per 100 c.c. of serum. The Wassermann test was negative. At the time of operation she had 88 per cent hemoglobin, 4,550,000 red blood cells and 7,800 white blood cells per cu. mm. of blood, and an icterus index of 75.

She was prepared for surgery with blood transfusions, amino acids and other intravenous medication, vitamins, including large doses of vitamin K, and supportive care. The patient was "worked up" and referred to us by Dr. Robert R. Hottel.

The operation was done in one stage and consisted of a cholecystectomy, exploration of the common bile duct, resection of the duodenum and a small portion of the stomach and resection of the head of the pancreas, which involved the tumor. We then did an end-to-side gastrojejunostomy. Transplantation of the common bile duct and the pancreatic duct into the jejunum was carried out distal to the gastrojejunostomy. An end-to-side jejunojejunostomy was performed to sidetrack the enteric stream.

There was no gross evidence of metastasis. The gall bladder was small, thick-walled and contracted down on numerous moderate-sized stones. The common duct, which contained a few small stones, was enlarged and distended with thick, dark green bile. There was a palpable tumor in the ampullary region and in the bead of the pancreas. The liver was slightly enlarged but showed no gross lesions.

The operation was performed on February 25, 1946 at Sibley Memorial Hospital under fractional spinal anesthesia administered by Dr. X. Charles Suraci. During the operation, which took 4½ hours, the patient received whole blood transfusions and saline infusions. There was no surgical shock following the operation, and the patient made an immediate excellent recovery. She was out of bed on the fifth day and was discharged from the hospital 21 days after the operation.

On cut section the gross specimen revealed a hard, gritty, white mass in the region of the ampulla of Vater. The growth completely occluded the common bile duct and the pancreatic duct. Extending from the mass into the body of the pancreas and into the duodenum there were white streaking, infiltrating radiations which had the appearance of carcinoma. Microscopic examination by Dr. Oscar B. Hunter of sections from the pancreas revealed a number of areas showing neoplastic cells growing in a mildly haphazard fashion and spreading by direct extension and what appears to be lymphatic infiltration. Examination of the adjacent duodenum reveals spread of the neoplastic cells to this structure with a number of small islands scattered in the musculature. The picture is that of a duct-cell carcinoma of the head of the pancreas with direct extension to the duodenum.

SYMPTOMS

Symptoms of carcinoma of the ampulla of Vater and head of the pancreas include pain, jaundice, weight loss, fatigue, weakness, anorexia, nausea, vomiting, constipation and diarrhea. Patients with vague inexplicable abdominal pain and any of these symptoms should have a thorough investigation of their pancreatic functions.

Schiff[3] states that pain is common. In our experience pain is present more often than not. The pain may be epigastric, in the upper abdominal quadrants, para-umbilical, or in the scapulae regions. It may follow or precede the jaundice. The pain may be gnawing, deep-seated, aching, dull, boring, colic, intermittent, or persistent. It is variable as to character and location. Pain has been explained by blockage of the pancreatic duct, by compression, dilatation of the biliary ducts, invasion of nerve sheaths, erosion of the duodenal mucosa, hepatic metastases or peritoneal involvement. Usually pain may be relieved by sitting or bending forward and aggravated by lying. On the other hand, we recently performed a total pancreatectomy for carcinoma of the pancreas on a patient who had epigastric pain only in the sitting position.

There is often obstructive jaundice with a distended gall bladder following Courvoisier's law (that obstruction within the duct leads to a thick-walled, shrunken gall bladder, whereas obstruction due to pressure from without results in a thin-walled, dilated one). Courvoisier's law does not always hold true, and in this patient it was not applicable.

The intense and deep green to bronze jaundice is usually painless, progressive and obstructive.[4] Late in the disease obstructive jaundice causes considerable liver damage; thus, as the disease progresses the findings in hepatocellular and obstructive jaundice tend to be similar. A decrease or temporary disappearance of jaundice may be attributable to sloughing of the tumor or possibly to subsidence of local edema. There may be generalized pruritus and bradycardia. Anorexia and weight loss are common features but are not always present. Early symptoms may simulate gall bladder disease or gastrointestinal disease. Hematemesis and melena are most infrequent. They have been explained by erosion of the pancreatic tumor into the stomach or duodenum, or rupture of esophageal varices secondary to neoplastic invasion and thrombosis of the splenic or portal vein.

Laboratory examinations and tests, as a rule, are helpful when positive and of little significance when negative. Those most suggestive are a persistent jaundice indicated to a degree by the icterus index, Van den Bergh reaction, and other measures. Absence of urobilinogen in the urine indicates absence of bile in the bowel, indicating the complete obstruction produced by the carcinoma. Occult blood in the stool would strongly suggest malignancy. However, the stools may be clay-colored and the urine dark and foamy. Stools may also reveal excess fat and protein because of blockage of the pancreatic duct and impairment of digestion of fats and protein.

Findings may reveal anemia, hyperlipemia, fatty or bloody stools, positive roentgen signs, impaired dextrose tolerance test, hyperglycemia, and glycosuria. Marble[5] found carcinoma of the pancreas more common in diabetics than in nondiabetics. The blood should be examined to rule out a hemolytic jaundice, and the red cells studied for fragility. Roentgenograms may show dislocation or distortion of the duodenum and widening of the duodenal curve or a reversed figure "3" in advanced cases.[6] Blood amylase and lipase, which are elevated in obstructions of the pancreatic ducts, may be suggestive.[7] Samples of duodenal juice obtained by intubation may be analyzed for pancreatic ferments.

Physical findings may include evidence of recent weight loss, marked icterus, a palpable liver with smooth, rounded edges, a palpable gall bladder and spleen, and a pancreatic mass. There may be ascites. Ascites may be due to involvement of the portal vein or implantation of growths on the peritoneum.[3] Ascites is seen more frequently in carcinoma of the body and tail. The spleen may be enlarged because of pressure on the splenic veins which may lie within or above the pancreatic body.

DIAGNOSIS

The clinical diagnosis of carcinoma of the pancreas is the concern of the general practitioner and internist as well as the surgeon. It is the former who usually sees these patients first. The interval between the first tell-tale symptoms and surgical treatment of this disease must be shortened if we are to effect cures. Unfortunately, many patients with carcinoma of the pancreas do not present clinical symptoms until the disease has progressed too far for surgery to offer much of a curative nature, or the patients have been observed and studied beyond the time interval when surgery would be helpful. Many patients who seem clinically operable will be found to be inoperable as far as radical surgery is concerned at the time of operation and vice versa.

We feel that every patient who has an obstructive jaundice is entitled to an exploratory operation. Furthermore, surgery should not be delayed too long. Erb[4] believes that in the event of nonsurgical pathology the harm to the patient resulting from surgical exploration can be kept at a minimum with adequate preoperative preparation and proper anesthesia. According to Moore[8] carcinoma involves the head of the pancreas about 3 times as often as the body in the middle- and old-age groups. It is approximately 3 times as common in males as in females. Brunschwig[9] states that carcinoma of the ampulla of Vater affects males twice as often as females. Tumor growth is confined largely to the head of the pancreas and the duodenum and produces symptoms chiefly through invasion and compression. Metastases are usually confined to the regional lymph nodes and liver. Erb[4] has developed a useful table to aid in the differential diagnosis of surgical and nonsurgical jaundice of the hepatocellular variety. Tables by Berk[10] on symptoms and laboratory findings in carcinoma of the pancreas are also very helpful.

To arrive at a surgical diagnosis the duodenum is completely mobilized and the head of the pancreas palpated from above and below between the fingers of both hands. Actual palpation will most often aid in determining if the lesion is malignant. The decision as to malignancy and as to radical operation must be made by the surgeon at the operating table. Benign adenoma or chronic pancreatitis may closely simulate carcinoma.

Orr[2] states that a stone impacted at the ampulla may be mistaken for carcinoma If in doubt a correct diagnosis of stone can easily be made by duodenotomy. Orr and Brunschwig advised that in selected doubtful cases or in which the tumor may escape detection by palpation a duodenotomy and biopsy may be desired. This procedure provides direct visualization of the ampullary region and duodenal mucosa. If diagnosis is not clear after biopsy a 2-stage operation is advised.

Child[11] states that most ampullary tumors are malignant, few are benign, and that most malignant tumors of the head have their origin deep in the gland itself; as they grow, they produce a capsule of chronic pancreatitis by compression and obstruction. Lee[12] claims that a microscopic report of chronic pancreatitis may or may not indicate a malignancy because as the tumor grows it obstructs small ducts and a chronic inflammation will develop about the tumor. This encirclement of the tumor is of varying thickness, and it may be that this layer will be all that is removed for biopsy and the actual tumor missed. Chronic pancreatitis, benign adenoma, and common duct stones may simulate carcinoma and may lead to radical pancreaticoduodenectomy, as reported by Horsley.[13]

We have performed a surgical biopsy of a pancreatic tumor in a doubtful case. Microscopic examination by the frozen section technic revealed carcinoma. The first stage of a radical pancreaticoduodenectomy was performed. Later, paraffin sections of the same pancreatic tissue revealed a benign lesion. No further surgery was performed. The patient is asymptomatic and well 2½ years later. In 3 cases of radical pancreaticoduodenectomy for carcinoma of the head of the pancreas and in 1 case of total pancreatectomy the diagnosis was made in each patient by manual palpation of the carcinoma at the time of the operation. Subsequent microscopic examinations of the excised tissue substantiated the surgical diagnosis.

JUSTIFICATION FOR THE ONE-STAGE OPERATION

It is most widely held today that the 1-stage operation is the best in most cases. Whipple[14] advocates the 1-stage operation, and he is credited with having done the first 1-stage removal of the head of the pancreas and duodenum. Some factors which justify the operation are:

1. Early diagnosis; these patients are less debilitated and less deeply jaundiced.
2. Improved preoperative care to improve the general condition of the patient so that he will tolerate with reasonable safety the necessary extensive and prolonged operative procedures.
3. Proper preparation of aged patients in order that they may tolerate hours of surgery and adequate support during the operation.
4. Improved methods of anesthesia, such as continuous and fractional spinal anesthesia, together with transfusions of whole blood, plasma and fluids.
5. Marked improvement and perfection of the technical operative procedures of this operation during the past 5 years.
6. Control of the dangers of hemorrhage and postoperative oozing by preoperative vitamin K therapy. Vitamin C and vitamin P are of some benefit. Human fibrin foam with thrombin, oxycel and similar products are helpful aids.

7. Better means to prevent and control shock.
8. Chemotherapy and antibiotics to prevent and control infections.
9. Newer knowledge of physiologic functions of the pancreas and replacement therapy that has given us a clearer understanding of the surgical significance of the operation.
10. Improved postoperative care including Wangensteen suction, replacement therapy, transfusions, vitamins, early ambulation, and supportive devices.
11. Danger in the 2-stage operation of 2 anesthesias and 2 major operations.
12. Increased technical difficulties with a second operation.
13. General belief according to Orr[2] that carcinoma arising in the papilla of Vater or ampulla grows slowly and metastasizes later. If true, a high percentage should be curable by early radical operation in 1 stage.
14. Knowledge as shown by Saltzstein and Rao[15] that involvement of the stomach, duodenum, middle colic vessels, and even a portion of the portal vein are not absolute contraindications to wide removal. Such resections represent an attempt at cure or long arrest, not palliation for a few months. They report a case of carcinoma of the pancreas which was proved by laparotomy biopsy in 1941 and in which at autopsy in 1945 the tumor was still local and resectable. However, throughout the rest of their paper they present evidence that carcinoma of the pancreas is notoriously a disease of short duration, and in support of this view they quote Cecil, Brunschwig and Ranson.
15. Reduction of the causes of death which include hemorrhage, peritonitis, duodenal and pancreatic fistulae, shock and pneumonia by improved preoperative care, surgical technic, 1-stage operation, and postoperative care.

The Surgical Technics

A small partial gastric resection was done in our case. The distal cut end of the stomach was anastomosed to a loop of jejunum. Strode[16] states that it is well known and becoming more firmly established that anastomosing the jejunum to an intact stomach is followed in a high percentage of cases by gastrojejunal ulcers. By removing the distal end of the stomach, which is the portion of the stomach that supposedly stimulates the acid-secreting cells of the fundus, we decrease the normal gastric acid secretion and help prevent the subsequent development of a gastrojejunal ulcer.

Practically the entire duodenum was removed because much of it was involved in the growth. During the operation the blood supply to the duodenum is impaired. Duodenal stumps or blind duodenal pouches frequently develop fistulae at the site of closure, and the physiologic functions of the duodenum, such as the elaboration of the hormone secretin, are taken up by the stomach and jejunum. The gall bladder was removed because it was pathologic and filled with stones. The common bile duct was anastomosed to the jejunum.

Trimble,[17] Whipple and others[18] advise the use of the common duct as a means of anastomosis instead of the gall bladder. We believe it facilitates drainage, prevents leakage, fistulae and infection. Strode[16] states that cholecystogastrostomy has in the past resulted in a high incidence of ascending hepatic infection, particularly due, it is thought, to the vigorous gastric peristalsis forcing food particles and gastric fluids up the ducts. In cholecystogastrostomies there is often a kinking of the common bile duct. To eliminate the possibility of cholangitis, which is likely when the stomach and gall bladder are united, a loop of jejunum is used to establish the continuity of biliary flow. Lee[12] reports that many of the previous cases, in which the gall bladder has been anastomosed to the intestinal tract, developed a biliary fistula because of failure of the common duct to stay tied off. Varco[6] adds that the cholecystoenterostomy failed to function and stricture developed. Whipple[18] says that a "blowout" of the ligated end of the common duct may produce the serious effect of infection. Cole[19] encountered suppurative cholangitis in several patients in those cases in which a vitallium tube was used at the anastomotic line between the common duct and jejunum.

In our patient the common duct was dilated and the anastomosis was made, easily providing decompression and drainage of the biliary tract. According to Whipple the bleeding tendency is corrected and digestion of fat improved.

The pancreas was transected an adequate distance away from the palpable induration and fibrosis about the tumor. The normal flow of pancreatic external secretion was reëstablished by anastomosing the pancreatic duct and the body of the pancreas itself to the jejunum. The method used was similar to that employed by Cattell[20] and Poth.[21] We believe that the pancreatic flow was maintained because of the precise surgical technic, by normal stools, by absence of a pancreatic fistula, and by the patient's gain in weight. With the emptying of the pancreatic juice directly into the jejunum the danger of causing a pancreatic fistula would be eliminated, or at least the chances of its occurrence greatly lessened.

Whipple[14—b] and Cattell[20] and many others state that the open pancreatic duct and the continued normal flow of pancreatic juice into the intestinal tract is sound physiology. This is accomplished by anastomosing the pancreatic duct or the severed end of the pancreas itself to the jejunum.

Brunschwig[9] and others believe in ligation of the pancreatic duct and closing the transected end of the pancreas. It is claimed that the other procedures are unnecessary and time-consuming and that the pancreatic duct will stenose in spite of the anastomosis.

The pancreas is composed of acinar cells and island cells.[22] The acinar cells produce the external secretions consisting of proteolytic, amylatic and lipolytic enzymes to the extent of 500 to 1,500 c.c. daily. The island cells are of 2 types, the alpha and beta cells. The alpha cells produce lipocaic according to Dragstedt[23, 24] and have to do with fat metabolism. Destruction of these cells produces hypolipemia and fatty infiltration of the liver. Oral lipocaic and pancreatic concentrates have been beneficial in preventing fatty degeneration of the liver. The beta cells produce insulin and are concerned with carbohydrate metabolism. Mullen[25] states that very few islands are required to carry on. Strode[16] says that it has been found both experimentally and clinically that diabetes occurs only when over 90 per cent of the pancreas is removed. Diabetes following total pancreatectomy may be less severe and more easily controlled than that occurring following partial resection of the pancreas.

When the pancreatic duct is ligated or obstructed the pancreatic remnant consisting of the tail and portion of the body undergoes cystic degeneration, atrophy and eventually becomes replaced by fibrous tissue.[25] The acinar cells are destroyed in time and the function of their secretion is taken up in most cases by the secretions of the stomach and bowel. However, there is for a while impaired absorption of all the food elements, particularly fat, and the patient has a resultant marked weight loss and many have voluminous fatty stools. With the loss of pancreatic juice the patient will need pancreatic concentrates, lipocaic, etc.

Human life is compatible with the absence of external pancreatic secretions, but there is definite evidence that their absence seriously impairs fat and protein absorption.[21] Interference with the normal flow of the external secretions of the pancreas will result in profound alterations in total metabolism. There occurs a fatty diarrhea, steatorrhea, the presence of undigested meat fibers showing transverse striation, creatorrhea, and an increase in nitrogen content of the stool (azotorrhea).[16] Schnedorf and Orr[7] found fatty infiltration and degeneration of the liver at autopsy in 10 of their 52 patients with carcinoma of the ampulla and head of the pancreas.

The feeding of lecithin, choline, pancreatic extract, or lipocaic is indicated in the preoperative and postoperative treatment of these patients to prevent fatty changes in the liver and to maintain life. Fatty infiltration and degeneration of the liver occur following total pancreatectomy. It also may follow a loss of pancreatic juice in total fistula, pancreatic fibrosis, pancreatic lithiasis or atrophy, ligation of the pancreatic ducts and other conditions which produce extensive functional destruction of the pancreas. Most often there is no associated diabetes. The process of fatty infiltration of the liver, fibrosis of the pancreas, and other changes are known to occur more slowly in humans than in animals.

Both Blalock[26] and Child[11] have pointed out that some people get along without the external pancreatic secretions; others get along without it but lack the full digestive powers for fat and proteins, while still others lack these powers and do poorly. One cannot predict what the patient will do following operation.

With regard to pancreatic fistulae we find that the general nutritional state of the patient is directly proportional to the severity of the fistula. There may be marked alteration in water balance, plasma protein level, and plasma electrolytes. Sodium loss may produce a syndrome similar to Addison's disease. When the patency of the pancreatic duct is maintained and the external secretions permitted to flow into the intestinal tract there is little change in the pancreas or liver and little disturbance of digestion and absorption. The pancreas continues to function, and normal body physiology is maintained. Under any circumstances, with or without pancreatic duct ligation, the island cells persist to a considerable extent and the patient does not develop diabetes.

Finally, a jejunojejunostomy distal to the anastomosis of the common bile duct and pancreatic duct prevents passage of the enteric stream over the anastomotic areas, keeps them relatively clean, and lessens the opportunity for regurgitation, infection, blockage and stenosis.

CONCLUSIONS

Radical pancreaticoduodenectomy is the operation of choice in carcinoma of the ampulla of Vater and the head of the pancreas.

The 1-stage operation is preferable and justifiable. It fulfills the fundamental principles of cancer surgery by removing en bloc tissue wide of the malignant growth including its regional metastasis. Palliative and short-cutting operations are not satisfactory.

With earlier diagnosis, improvement in pre- and postoperative care, and in operative technic, more operations can be performed with lower mortality. Obstructive and painless jaundice should be surgically investigated without long delay.

Choledochoenterostomy and pancreaticojejunostomy more nearly reëstablish normal physiology and at the same time reduce the opportunity for operative complications and metabolic disturbances.

We have reported a case of radical pancreaticoduodenectomy for carcinoma of the head of the pancreas, in which the flow of bile and pancreatic juice into the intestinal tract was reëstablished. No substitution therapy has been used. The patient is very well 18 months after the operation.

BIBLIOGRAPHY

1. Whipple, A. O.: Ann. Surg., 1941, **114**, 612.
2. Orr, T. G.: Surgery, 1945, **18**, 144.
3. Schiff, L.: The Differential Diagnosis of Jaundice. Chicago: Yr. Bk. Pub., 1947.
4. Erb, W. H.: S. Clin. North America, 1944, **24**, 1370.
5. Marble, A.: New England J. Med., 1934, **211**, 339.
6. Varco, R. L.: Surgery, 1945, **18**, 569.
7. Schnedorf, J. G., and Orr, T. G.: Ann. Surg., 1941, **114**, 603.
8. Moore, R. A.: A Textbook of Pathology. Philadelphia: Saunders, 1944.
9. Brunschwig, A.: The Surgery of Pancreatic Tumors. St. Louis: Mosby, 1942.
10. Berk, J. E.: Arch. Int. Med., 1941, **68**, 525.
11. Child, C. G., III: Ann. Surg., 1944, **119**, 845.
12. Lee, H. C.: Virginia M. Monthly, 1945, **72**, 333.
13. Horsley, J. S.: Ann. Surg., 1941, **113**, 802.

(Continued on page 531)

THE TREATMENT OF NONSPECIFIC ULCERATIVE COLITIS*

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Associate in Medicine, Columbia University College of Physicians and Surgeons

THE treatment of nonspecific ulcerative colitis poses a difficult therapeutic problem to the practitioner of medicine. The acute fulminating phase of the disease, a phase which is being seen with increasing frequency, is a most serious malady with a high mortality and one very difficult to combat failing a "specific" approach to therapy. The chronic form of ulcerative colitis is unfortunately marked by its great tendency to recur. The recurrences are sometimes spaced as long as 20 years apart. A direct permanent acquired immunity to the disease does not seem to exist, and yet a material percentage of the cases are so improved, or so-called "cured" that good health and well-being are restored for a long period of time.

The therapy of the case of chronic recurrent nonspecific ulcerative colitis is in general supportive. These measures include the customary repeated transfusions, intravenous injections of plasma, or even better, the intravenous injections of hydrolysed protein products, of which there are many on the market by many trade names, Amigen, protein hydrolysate, etc. The replacement of the depleted protein reserves of the body is very important, since the diarrhea washes out of the intestine the normal digestive products and gives rise to a relative and absolute hypoproteinemia. It would be well if the patient could digest the hydrolysed proteins by mouth, but their disagreeable taste and the anorexia that accompanies colitis make this an impractical procedure. The anemia and the vitamin depletion again call for replacement, but again the administration of the vitamins by mouth in the presence of a violent diarrhea defeats its own purpose. Therefore, intramuscular injections of crude liver extract and vitamin B complex represent a sure method of replacing essential vitamins. The dose of each of these ingredients should be 1 to 2 c.c. of each, the injections being repeated every day or every alternate day.

Specifically we should like to feel that the sulfonamides, particularly the insoluble forms, would act as antibiotics and overcome intestinal infection. In practice, however, even the insoluble sulfonamides are disappointing. There are exceptions to this statement, and there are many cases that seem to react specifically to these sulfa preparations. Sulfasuxidine in doses of 0.25 grams per kilogram of weight, or sulfathalidine, 0.1 gram per kilogram of weight, should be tried, and persistently tried, in every case. These drugs are relatively insoluble in the intestinal tract, are with rare exception nontoxic, and can be administered over a long period of time, perhaps months. The only warning is to watch out for a possible hemolytic anemia. Penicillin is useless in ulcerative colitis. Streptomycin by mouth or by injection for the chronic afebrile type of ulcerative colitis again has failed to show any beneficial effect.

For the afebrile type of ulcerative colitis, indolent, protracted, with diarrhea, loss of weight, and secondary anemia, the best therapeutic attack in my experience is nonspecific shock protein therapy. For this purpose I utilize typhoid vaccine giving an intravenous injection of 50 million bacteria every fifth day, increasing successive doses by 25 million. The vaccine should be injected intravenously, should produce chill and an abrupt rise in temperature, but should allow a rapid decline of the temperature to the normal base line within 24 hours. This form of therapy is strikingly successful in a large proportion of the cases of indolent protracted cases of colitis. As for diet, I am exceedingly lenient in my views, allowing the patient everything except roughage. Raw fruits and vegetables must be excluded, but apart from that I am glad to cater to the anorexia by allowing any food which will tempt the appetite. The only exception would be the restriction of milk in those cases which are known to be allergic to milk products.

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* Summary of an address delivered before the Society, February 12, 1947.

As to the acute fulminating, severely toxic, febrile forms, these patients must be maintained with much intravenous therapy and transfusions. Sulfa preparations should be pushed but are not usually successful. I have had several very successful results with streptomycin. The streptomycin is given in doses of 2 grams daily, $\frac{1}{2}$ gram given intramuscularly every 6 hours and continued for 5 to 8 days. The results are often absolutely striking. Streptomycin given by mouth should theoretically be efficacious, since it is not absorbed in the intestinal tract and should act as a local antibiotic. Many clinicians combine the method of giving streptomycin by mouth and intramuscularly. I am not convinced that the oral administration is of any value. My experience to date, in which I have been using streptomycin in cases of acute ulcerative colitis (10 cases), has been promising in at least 8 cases, and I should say that in 4 of these the therapeutic result was most impressive and immediate.

As for the surgical approach, in acute fulminating colitis, when absolutely desperate and defeated by every conservative method, ileostomy may save life. However, the mortality of ileostomy in acute colitis is exceedingly high, probably averaging about 40 per cent, if not more.

In the case of chronic intractable ulcerative colitis in which every form of therapy has failed, a double-barreled ileostomy is indicated to restore the patient to a state of balanced nutrition and to efficiency. This is a life-saving operation followed by a rapid gain of weight and nutrition. The patient cares for his ileostomy with relative ease and becomes a working member of the community instead of an invalid. A colectomy should follow every ileostomy to avoid the possibility of malignant degeneration of the polypoid changes which occur in the sidetracked large bowel. In most cases the rectum is preserved. Occasionally the rectum is either not involved originally or has healed completely following the ileostomy and the colectomy. In rare instances the ileostomy can be taken down at some subsequent time and implanted into the rectum with restoration of the continuity of the alimentary tract.

President's Page

THE ASSEMBLY GROWS

The 18th Annual Scientific Assembly will open a three-day session at the Hotel Statler on Monday, October 6, 1947. This meeting will mark another high point in the history of our Society.

The Medical Society of the District of Columbia was founded in 1817, which makes this the one hundred and thirtieth year of its existence. The Assembly was first held in 1929, making this its eighteenth birthday.

As the Society has grown, so has the Assembly. Beginning as a one-day meeting held in the building at 1718 M Street, it has increased in size and importance so that the space and time allotted at present are hardly sufficient. The work necessary to organize and present the Assembly is tremendous. It is only possible through the untiring efforts and sacrifice of the General Chairman and his committees.

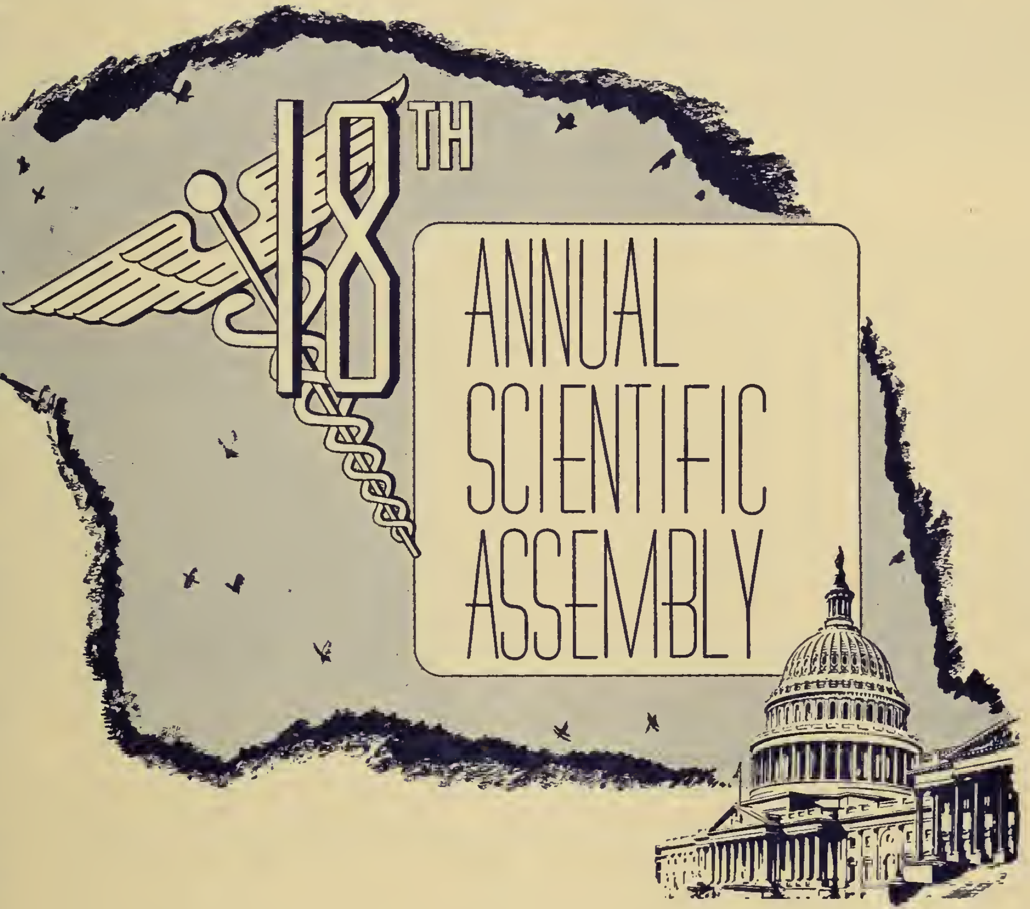
This year an exceedingly fine scientific program has been arranged. The scientific exhibits will be better than ever before and the technical exhibitors will again be showing the very newest in their aids to the medical practitioner. A new feature, the Public Health Exhibit, has been added. It is designed to familiarize the public with recent developments in medicine.

We should all be proud of the Assembly as it is one of the outstanding sectional meetings in the country. In appreciation of this, we should plan to attend all sessions possible in order to obtain the maximum benefit and pleasure from them.

Remember the dates, October 6, 7 and 8, 1947; the time, 10:00 a.m. to 5 p.m. daily; the place, Hotel Statler, Washington, D. C.

Raymond T. Holden

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA



18TH ANNUAL SCIENTIFIC ASSEMBLY

OCTOBER 6-7-8, 1947
HOTEL STATLER
WASHINGTON, D. C.

Medicine in the Atomic Age

Hotel Statler

With the advent of a new era in science, the theme chosen for the 18th ANNUAL SCIENTIFIC ASSEMBLY—*Medicine in the Atomic Age*—is peculiarly appropriate. Although research workers have made little progress in the adoption of atomic energy for medical purposes and its clinical use still lies in the future, its potentialities hold great promise. In the meantime, research in the atomic field has stimulated progress in other branches of medical science. Discussions of these developments have been included in the ASSEMBLY program.

An examination of the program which appears on the following pages will reveal its broad scope and general excellence. An equally high standard, it will be observed, has been maintained in the Scientific Exhibit, where demonstrations have been selected with the greatest care. Motion pictures will be shown in a room adjacent to the Exhibit, as in previous years. In addition, there will be a new feature—television. Plans have already been completed for televising an operation from a Washington hospital to the Statler.

Another new feature is the Public Health Exhibit. The Exhibit is sponsored by official and voluntary health organizations of the District of Columbia, including the Medical Society. It will be open to the public throughout the three days of the ASSEMBLY.

Luncheons will again be sponsored by the Medical Society, the George Washington University Medical Society, and the Georgetown Medical Alumni Association. The Annual Dinner will, as usual, bring the ASSEMBLY to a close. Past Presidents of the Medical Society and their wives will be the guests of honor. Dr. Edward L. Bortz, President of the American Medical Association, will be the speaker. A memorable evening is in store for members, visitors and their guests who participate.

The 1947 Committee on Arrangements has endeavored to maintain the high standard set by previous committees. How well it has succeeded, you who participate must judge. The Committee will be amply rewarded for its rather strenuous efforts if you find pleasure and profit in this year's ASSEMBLY.

Make your plans now to be present on all three days of the meeting. Note the dates now on your calendar—October 6, 7 and 8.

Robert H. Groh

GENERAL CHAIRMAN
COMMITTEE ON ARRANGEMENTS

Medical Society Building

18th Annual Scientific Assembly

SCIENTIFIC PROGRAM

All Sessions in the Presidential Ballroom, Hotel Statler

MONDAY, OCTOBER 6
MORNING SESSION

LESIONS OF UPPER GASTROINTESTINAL TRACT

10:00 Recognition and Management of Esophageal Disease
Herbert Schmidt, M.D.
Mayo Clinic

10:40 Esophageal Lesions Revealed by X-Ray
Aubrey O. Hampton, M.D.
Washington

11:00 Recess

11:15 Present Trends in Gastric Surgery
John H. Garlock, M.D.
Clinical Professor of Surgery, College of Physicians and Surgeons, Columbia University

11:45 Recess for Luncheon

MONDAY, OCTOBER 6—AFTERNOON SESSION

2:00 The Role of the Pancreas in Gastro-intestinal Disorders
Henry L. Bockus, M.D.
Professor of Gastroenterology, Graduate School, University of Pennsylvania

2:40 What Can Be Done for Cirrhosis of the Liver?
Harold J. Jeghers, M.D.
Director, Department of Medicine, Georgetown University School of Medicine

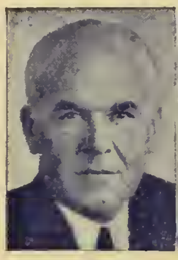
3:05 Recess

3:15–4:30 Panel Discussion on Upper Extremity Pain

—of Orthopedic Origin
I. William Nachlas, M.D.
Assistant Professor of Orthopedic Surgery, Johns Hopkins Medical School

—of Neurologic Origin
Barnes Woodhall, M.D.
Professor of Neurosurgery, Duke University School of Medicine

—of Vascular Origin
Gerald H. Pratt, M.D.
Assistant Clinical Professor of Surgery, College of Physicians and Surgeons, Columbia University


Dr. Bockus

Dr. Dowling

Mr. Escavaille

Dr. Hampton

Dr. Hertz

Dr. Jeghers

Dr. Marchetti

SCIENTIFIC PROGRAM

TUESDAY, OCTOBER 7—MORNING SESSION

CARDIOVASCULAR DISEASE

10:00 Surgery of Hypertension

Geza de Takats, M.D.

Associate Professor of Surgery, University of Illinois College of Medicine

10:30 Pseudoangina

John T. King, M.D.

Associate Professor of Medicine, Johns Hopkins Medical School

10:50 Recess

11:00 The Medical Management of Hypertension—Rice Diet

Walter Kempner, M.D.

Assistant Professor of Medicine, Duke University School of Medicine

11:45 Recess for Luncheon

TUESDAY, OCTOBER 7—AFTERNOON SESSION

2:00 Diagnosis and Treatment of Carcinoma of the Uterus

Richard W. Te Linde, M.D.

Chief Gynecologist, Johns Hopkins Hospital

2:30 The Management of Common Obstetrical Difficulties

Andrew A. Marchetti, M.D.

Professor of Obstetrics and Gynecology, Georgetown University School of Medicine

3:00 Recess

3:10–4:30 Panel Discussion on Hyperfunctioning Endocrine Tumors

—Parathyroid

Joseph C. Aub, M.D.

Director, Cancer Commission of Harvard University

—Adrenal Gland

Meyer M. Melicow, M.D.

Instructor in Urology, College of Physicians and Surgeons, Columbia University

—Gonads

Roy Hertz, M.D.

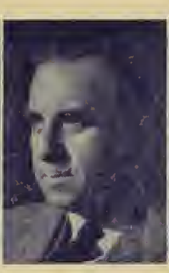
Chairman, Endocrinology Section, National Cancer Institute

Dr. Melicow

Dr. Nachas

Dr. Pratt

Dr. Schmidt


Dr. Stieglitz

Dr. Te Linde

Dr. Tuohy

SCIENTIFIC PROGRAM

WEDNESDAY, OCTOBER 8—MORNING SESSION

10:00 STATUS LYMPHATICUS
John Caffey, M.D.
Associate Professor, Department of Pediatrics, College of Physicians and Surgeons, Columbia University

10:35 THERAPY OF THE AGED
Edward J. Stieglitz, M.D.
Washington

11:00 RECESS

11:15 SUBDURAL HEMATOMAS OF NEWBORN
Douglas Buchanan, M.D.
Assistant Professor of Pediatrics, University of Chicago School of Medicine

11:45 RECESS FOR LUNCHEON

WEDNESDAY, OCTOBER 8—AFTERNOON SESSION

2:00 NEWER APPROACHES IN THE CARE OF THE ALCOHOLIC
E. M. Jellinek, Sc. D.
Director, Section on Alcohol Studies, Yale University

2:30 ALCOHOLICS ANONYMOUS
William M. Escavaille, Jr.
Washington

2:45 NEWER DEVELOPMENTS IN ANESTHESIA
Edward B. Tuohy, M.D.
Professor of Anesthesiology, Georgetown University School of Medicine

3:25 RECESS

3:35–4:30 PANEL DISCUSSION ON ANTIBIOTICS

—EXPERIMENTAL TRENDS
Paul A. Bunn, M.D.
Assistant Director, Department of Medicine and Surgery, Veterans Administration

—IN THE TREATMENT OF INFECTIOUS DISEASES
Harry F. Dowling, M.D.
Clinical Professor of Medicine, George Washington University School of Medicine

—IN THE TREATMENT OF TUBERCULOSIS
John Barnwell, M.D.
Chief, Tuberculosis Division, Department of Medicine and Surgery, Veterans Administration

The Scientific Exhibit

The Scientific Exhibit will be on display in the South American Room at the Hotel Statler. Motion pictures will be shown in the Private Dining Room No. 1 which adjoins the South American Room.

Subjects	*Sponsors*
Activities of the Medical, Surgical, and Laboratory Services of Children's Hospital:	
"The Outpatient Department"	John A. Washington, M.D., Director, Outpatient Department
"Neurological Changes Following Kernicterus (Erythroblastosis Fetalis)"	Ralph Stiller, M.D.
"Cystic Fibrosis of the Pancreas"	Nicholas Pistolas, M.D.
Atabrine Dermatoses	E. E. Barksdale, M.D., Yater Clinic
Convalescent Care of Children	Margaret Mary Nicholson, M.D.
Diagnosis and Management of Diabetes and Its Complications	The Diabetes Association of the District of Columbia, Inc.
Diagnostic and Treatment Problems in Backache	Maurice H. Herzmark, M.D.
Exsanguination Transfusion	John B. Ross, M.D., and Oscar B. Hunter, Jr., M.D.
Femoral Neck Fractures	Philip O. Pelland, M.D., and R. Clayton Rounds, M.D.
Hormonal Control of Tissue Growth	Roy Hertz, M.D., National Cancer Institute, U. S. Public Health Service
Hyperhidrosis, Surgical Management	J. Ross Veal, M.D., and John N. Shadid, M.D.
Lumbar Sympathectomy in Arterial Deficiency, Lower Extremity	Leon Gerber, M.D., and William McCune, M.D., Department of Surgery, George Washington University School of Medicine
Malignant Tumors of the Eye	M. Noel Stow, M.D.
Neuropathology	St. Elizabeths Hospital; Winfred Overholser, M.D., Superintendent
N.S.F. Preparations	Harold C. Kinner, Phar.D., Secretary, District of Columbia Pharmaceutical Association, Inc.
Oil-soluble Metals in Leukemia	Charles F. Geschickter, M.D., Department of Pathology, Georgetown University School of Medicine
Placenta Previa	Aubrey O. Hampton, M.D., Howard R. Crews, M.D., and John P. Moore, M.D., Department of Radiology, Garfield Memorial Hospital
Plastic and Reconstructive Surgery	Michael P. DeVito, M.D.
Protein Metabolism and Parenteral Protein Hydrolysate	Jacob Weinstein, M.D., George Washington University School of Medicine
Reproduction of Heart Sounds on Phonograph Records	Benjamin Manchester, M.D., George Washington University School of Medicine
Streptomycin in the Treatment of Tuberculosis	Veterans Administration
Surgical Treatment of Lung Abscess	Roy G. Klepser, M.D., Georgetown University School of Medicine
Syphilis—Diagnosis and Treatment	Bureau of Venereal Diseases, District Health Department; S. Ross Taggart, M.D., Director

The Technical Exhibit

The Technical Exhibit will be on display in the Congressional Room, immediately adjacent to the registration desk. Those who attend the scientific sessions will enter the Presidential Ballroom by way of the Congressional Room. Forty firms are participating in the Technical Exhibit. They are as follows:

Congressional Room, Hotel Statler

Ayerst, McKenna & Harrison, Ltd.	(Booth 1)
Beuchler's	(Booth 29)
Bilhuber-Knoll Corporation	(Booth 15)
Boomhower, D. W., Company	(Booth 32)
Borden Company	(Booth 36)
Brand, Paul L., & Son	(Booth 4)
Burroughs, Wellcome & Co. (U.S.A.), Inc.	(Booth 39)
Camel Cigarettes	(Booth 20)
Ciba Pharmaceutical Company	(Booth 14)
Davies, Rose & Company, Ltd.	(Booth 33)
Doak Company, Inc.	(Booth 12)
Doho Chemical Corporation	(Booth 23)
Fleet, C. B., Company, Inc.	(Booth 26)
Gibson Company	(Booth 3)
Haskell, Charles C., & Company	(Booth 31)
Kloman Instrument Company, Inc.	(Booth 16)
Lederle Laboratories	(Booth 8)
Liebel-Flarsheim Company	(Booth 19)
Lilly, Eli, & Company	(Booth 40)
Lippincott, J. B., Company	(Booth 2)
Luzier's, Inc.	(Booth 41)
Maxwell & Tennyson	(Booth 35)
Mead Johnson & Company	(Booth 30)
Merrell, William S., Company	(Booth 7)
Parke, Davis & Company	(Booth 37)
Peoples Drug Stores	(Booth 38)
Philip Morris & Company, Ltd., Inc.	(Booth 34)
Sanborn Company	(Booth 27)
Sandoz Chemical Works, Inc.	(Booth 17)
Saunders, W. B., Company	(Booth 24)
Searle, G. D., & Company	(Booth 21)
Sharpe & Dohme, Inc.	(Booth 13)
Smith, Kline & French Laboratories	(Booth 28)
Squibb, E. R., & Sons	(Booth 11)
Swift & Company	(Booth 9)
U. S. Vitamin Corporation	(Booth 18)
Walker Vitamin Products, Inc.	(Booth 22)
Washington Institute of Medicine	(Booth 6)
Winthrop Chemical Company, Inc.	(Booth 10
White Laboratories, Inc.	(Booth 25

Registration

Arrangements have been made again this year to register members of the Society before the opening of the Assembly. Those who find it convenient to do so can register at the Society's office on Friday, October 3, between 9 a.m. and 5 p.m., and on Saturday, October 4, between 9 a.m. and 1 p.m.

Visiting physicians, medical officers of the various branches of Government service, and Society members not previously registered may do so at the Hotel Statler beginning at 9 a.m. on Monday, October 6. Residents, internes, dentists, nurses, pharmacists, medical students and others invited can also register at that time. Badges and official programs are obtainable at the Registration Desk. No one will be admitted to scientific sessions or exhibits without a badge.

Members planning to attend the Society luncheon on Monday, October 6, should register before 1 p.m., Saturday, October 4. One ticket will be available to each Active member without charge. Due to the use of the Presidential Ballroom for scientific sessions, its capacity for the opening day luncheon is limited to 500. Associate members and non-members may purchase luncheon tickets at $3.00.

Visiting physicians and non-members of the Society, except medical officers of the Army, Navy and Public Health Service, and physicians employed by the Veterans Administration, will be required to pay a registration fee of $3.00.

Tickets for the luncheons given by the George Washington University Medical Society and the Georgetown University Medical Alumni Association may be obtained at the Registration Desk.

Synopsis of Program

(All meetings at the Hotel Statler)

MONDAY, OCTOBER 6, 1947

9:00 A.M.: Registration
10:00 A.M.-11:45 A.M.: Scientific Program
12:15 P.M.-1:30 P.M.: Medical Society Luncheon, Presidential Ballroom
SPEAKER: LOUIS M. A. KRAUSE, M.D., Associate Professor of Medicine, University of Maryland
SUBJECT: "Trends in Medicine"
2:00 P.M.-4:30 P.M.: Scientific Program

TUESDAY, OCTOBER 7, 1947

10:00 A.M.-11:45 A.M.: Scientific Program
12:15 P.M.-1:30 P.M.: Georgetown University Medical Alumni Association Luncheon, Presidential Ballroom
SPEAKER: MONSIGNOR FULTON J. SHEEN, Professor of Philosophy, The Catholic University of America
2:00 P.M.-4:30 P.M.: Scientific Program
6:30 P.M.: Women's Medical Society Dinner, Pan American Room
8:15 P.M.: Public Meeting, Presidential Ballroom
SUBJECT: "Our Youth Today—A Challenge to American Parents"; MR. G. HOWLAND SHAW, former Assistant Secretary of State, presiding
SPEAKERS: MIRIAM VAN WATERS, PH.D., Framington, Mass.; GEORGE E. GARDNER, M.D., PH.D., Boston; and J. EDGAR HOOVER, Director, Federal Bureau of Investigation

WEDNESDAY, OCTOBER 8, 1947

10:00 A.M.-11:45 A.M.: Scientific Program
12:15 P.M.-1:30 P.M.: George Washington University Medical Society Luncheon, Presidential Ballroom
SPEAKER: GEORGE F. LULL, M.D., Secretary and General Manager, American Medical Association
SUBJECT: "Activities of the Headquarters of the American Medical Association"
2:00 P.M.-4:30 P.M.: Scientific Program
7:30 P.M.: Past Presidents' Night (Annual Dinner), Presidential Ballroom
SPEAKER: EDWARD L. BORTZ, M.D., President of the American Medical Association
SUBJECT: "Medical Statesmanship"

(As stated elsewhere in the ASSEMBLY section, the Public Health Exhibit is open to the general public daily from 10:00 A.M. to 5:00 P.M.)

The Public Health Exhibit

An exhibit devoted entirely to recent developments in the health field will be open daily to the public throughout the ASSEMBLY. The hours during which the exhibit will be open are 10 a.m. to 5 p.m.

A public health exhibit has been under consideration by various committees in charge of the ASSEMBLY for some years. It was finally decided that this year was a propitious time to undertake the project. Official and voluntary health agencies invited to join with the Medical Society of the District of Columbia in sponsoring the exhibit and who have accepted are: The District Health Department, the District of Columbia Tuberculosis Association, the District of Columbia Division of the American Cancer Society, and the District Chapter of the American Red Cross. Financial contributions made by these organizations made the exhibit possible.

A complete list of exhibitors will appear in the official program. In addition to the sponsors, at least fifteen organizations and institutions have accepted invitations.

It is the firm belief of the Committee on Arrangements that this exhibit will be a forerunner of more ambitious ones, because the visual method of lay health education is generally considered the most effective.

The Public Health Exhibit will be set up in the Federal Room adjacent to the South American Room, where the Scientific Exhibit will be on display.

New Features

In a foyer off the second floor lobby of the Statler, there will be a unique display provided by the Georgetown and George Washington University Schools of Medicine. By means of historical documents, photographs and models, their past and present accomplishments, and future prospects will be depicted.

Television will also play its part in the ASSEMBLY for the first time. Surgical operations will be televised to the Statler from a Washington hospital. The purpose of this demonstration is to show the educational possibilities of television.

Editorials

THE HOSPITAL COUNCIL OF THE NATIONAL CAPITAL AREA*

A hospital council is initially an experiment in understanding. And from understanding must come coöperation for the good of the community. A successful hospital council must be of value not only to the hospitals but to the medical profession and to the public. It was with these broad aims in view that the Hospital Council of the National Capital Area was brought into being a year ago. Has it begun as it should and will it, in the future, fulfill its fundamental purpose?

Members of the Council are all the hospitals of the area accredited by the American Medical Association which desire to join. Every member hospital is entitled to three delegates, who are, normally, one from the governing body, one from the medical staff, and the administrator, thus insuring that all aspects of the hospital shall be represented. It is possible that later on the Council may decide to admit to membership representatives of outside bodies and of the public, but it seems at present both unnecessary and unwise to complicate the organization by duplicating on a smaller scale the make-up of the Metropolitan Health Council. The Hospital Council is, after all, a body created to deal with technical hospital problems. It can always, and often does, call on outsiders for advice and assistance on special matters just as it always stands ready to give advice and aid wherever and whenever a call is made. In the consideration of such special problems the Council is always glad to welcome those most interested to its meetings or to send delegates to outside meetings. Indeed in almost all cases members of the Council belong to the other organizations just as their members are represented on the Council.

The full Council has been meeting monthly, but as time goes on it will probably meet less often, entrusting its routine business to the Executive Committee of fifteen members elected by the Council and widely representative of the hospitals, and more and more depending on the studies made by this Committee of the various important problems that arise. The officers, a President, Vice President, Secretary and Treasurer, serve without pay, but it is clear that, to be of maximum service, the Council must have a salaried Executive Secretary who will always be on the job. This has been the development of all successful hospital councils. The salary of such an official should perhaps eventually be paid from a community fund as is done elsewhere and as was recommended in the report of the recent Survey Committee on health conditions in the metropolitan area. At first, however, until the Council has proved its usefulness to the public, this salary would probably be paid proportionately by all the hospitals that are members of the Council. It is believed that this added expense to the hospitals would be more than repaid, not only by the intangible benefits accruing by reason of the fact that someone was always on the lookout to protect and forward hospital interests, but also by many tangible benefits. The Executive Secretary, for example, would often have opportunities to purchase at a low figure various commodities in such large quantities as no single hospital could afford to take but which could profitably be shared by many hospitals. Such an officer would follow closely all legislation affecting hospitals, whether originating in Congress, in the District government, in Virginia or Maryland as it affected counties included in the metropolitan area of Washington. The Executive Secretary would be the chief coördinating officer, the eyes and ears and often the good right arm of the Council.

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* This is the nineteenth in a series of guest editorials by distinguished physicians and laymen.

Even as a wholly voluntary organization the Hospital Council has accomplished much—if not all that it should have—in the short term of its existence. It has made a study of salaries, which has already resulted in the adoption by most hospitals of the area in a new and more generous scale of pay for nurses. It is studying with care and sympathy the entire question of nursing. Similar studies are proceeding on the pay scales of all other employees. The purpose of this study is not only to assure fairness to all but to eliminate costly competition. Hospitals have only one aim, which is to serve the public. They all act on the same fundamental principles, are not money-making institutions. They must seek to secure their employees from outside, never to lure them with visions of higher pay from each other; they have to compete in this and many other matters with commercial establishments, but the only competition they should have with each other is in giving the best possible service to the public.

The Council has already shown that a group representing all hospitals of the area is a far better bargaining agency than smaller groups representing single hospitals. For example, all hospitals had been losing money by reason of wholly inadequate payments by Group Hospitalization, Inc. for the care of its clients. Group Hospitalization is not a commercial, money-making insurance company but, like the various Blue Cross plans, is run for the benefit of its clients, who pay their premiums in return for free hospital care when they become ill. The principal reason why these payments were too small to pay anything like the cost of hospitalization was that the facts had never been made clear. A committee of the Hospital Council therefore met with a committee of GHI and explained the dilemma of the hospitals. A tentative agreement was reached which made the situation better, and we believe that we have recently worked out a plan whereby the hospitals will receive the actual cost of the care of GHI patients, which is all that any hospital wants. Without this intervention of the Council the hospitals would probably, of dire necessity, have been compelled to cancel their contracts with GHI, thus reducing an extremely useful and valuable institution to impotence.

So also the Hospital Council can better carry on negotiations with the Federation of Community Chests and its agent for distribution, the Health Security Administration, than would be possible if every hospital had to negotiate separately. Also such a single agency can be more effective in presenting to the public a true picture of the work being done by all the hospitals for the medically indigent, thus dramatizing the need for generous assistance. Most people would agree that the hospitalization fund of the Federation of Community Chests fills a more vital and community-wide need than any of its other funds. The money is not a gift from the community to the hospitals. It is a part payment by the community for the care of its sick members who cannot pay themselves, a charity toward them and at the same time an insurance for all against the spread of disease. In the Washington area a very large part of the population considers itself nonresident and therefore not responsible, or only mildly responsible, for local charities. But in the Chest drive for funds all these people must be made to realize that payments for hospitalization are of direct benefit to them as much as to the permanent residents. For the sake of the health of the area, therefore, a committee of the Hospital Council recently urged Chest officials to allocate for hospital care of the indigent sick a larger proportion of the funds collected than has been done in the past. Washington hospitals have smaller endowments than hospitals in most other cities; they have a narrower basis of support, and it is unfortunate that the Federation of Chests should allocate to them a smaller proportion of total collections than is done elsewhere. All this was explained to a group of Chest officials by a committee of the Council, and the Chest officials said they had never before had a clear picture of the situation. It is unthinkable that any of the hospitals of the area, already undersupplied, should be forced to close for lack of funds. Now, in the drive of the Chest Federation for funds for next year, it is the duty of the Hospital Council, as well as of its members individually, to make the public understand the situation in order that public response to this particular and very urgent need may prove to Chest officials the necessity of generosity in allotments for the care of the medically indigent.

The efficient care given to patients in the hospitals of this region is probably unsurpassed in the Nation—and this in spite of the fact that most of our hospitals are old-fashioned and rundown, and also in spite of the fact that recent difficulties in securing adequate personnel have been almost unsurmountable. A member of the recent Survey Committee, a distinguished doctor from another city, said of the obstetrical department of one of our hospitals that it was inadequate, inconvenient, and sadly out-of-date. "And yet," he added, "if my daughter were going to have a baby I should be happy to send her here." He said this, of course, because he knew that the hospital has an admirable staff of doctors. This is generally true in the Washington area, and hospital boards as well as hospital administrators understand the necessity of keeping their medical staffs happy and satisfied. With the physical inadequacies of all except the newest hospitals, this is very difficult, and the Hospital Council fully understands that one of its principal aims must be to improve conditions throughout the area, not only for the sake of the patients but to enable the doctors to do their work under less strain and therefore more efficiently. The new Hospital Center, when it is built, and the new George Washington and Georgetown hospitals will make conditions better, but the Council has an unescapable obligation to work for the improvement and modernization of all remaining hospitals. It will always welcome suggestions from the Medical Society as to how it may be of service to the medical profession. It believes, for example, that much can be done for the younger generation of doctors by studying the training being given in the various hospitals to residents and internes, by inaugurating a concerted attempt to raise standards through improvement in methods, as well as by inspiring a larger sense of obligation on the part of those who teach.

Hospitals could not exist without doctors. But it is also true that, without well run hospitals, the doctor's task would be heavier and he would be deprived of many opportunities of service, many openings to improve himself. The Hospital Council will work steadily to bring about conditions as nearly ideal physically as may be possible; will assist in every way in the recruitment of nurses in adequate numbers and of the quality which will make them the trusted allies of the doctors in the alleviation of suffering and the saving of human lives. In a word, the Hospital Council is eager to do its part in making the National Capital famous for its admirable hospitals, and in enabling those hospitals fully to accomplish the humanitarian purpose for which they were built.

William R. Castle
President, Hospital Council of the National Capital Area

ON THE IMPORTANCE OF PERSPECTIVE

The more clearly and precisely we can see a target the better will be our score of direct hits. Seeing a target means more than merely detecting its existence; its composition, activities, potentialities, and time and space relationships to its environment are all important characteristics. Clarity of perception and completeness of comprehension are dependent upon the ability of the observer to apply perspective. No problem is an isolated entity; to be understood it must be seen in relation to other issues and subjects. Sense of proportion is derived from perspective.

We of the medical profession have sought responsibility by our selection of medicine as a career, recognizing the inseparable relationship between responsibility and privilege. Solving problems is the daily and continuous task of physicians. These problems are becoming increasingly complex, more and more urgent, and expanding in their significance. In the early days of medicine the physician's responsibilities were limited to the alleviation of individual suffering. To these concepts have been added the responsibility of preventing unnecessary disease, (in the ideal sense almost all disease is unnecessary) and, still more recently, of building greater health for all people. For centuries the physician had to wait for people to get sick and wait for the sick to seek guidance and relief. Attention has been so sharply focused upon disease that many of the profession have forgotten that the patient who has the disease is truly more important than the disease itself. Health construction is more than the treatment of disease.

Perspective is vital to diagnosis. No diagnosis is complete without consideration of etiology. Effectiveness of curative and preventive therapy is predicated upon accurate and complete etiologic diagnosis. Causation is never singular; many factors are involved, some obvious and recent and others obscure and past. Etiologic factors are usefully classified into three groups: (1) predisposing factors, (2) provoking factors, and (3) perpetuating factors. These may be endogenous or exogenous, environmental (social), nutritional, traumatic, or infective. The alarming increase in venereal disease all over Europe and Asia today is not due to any increased virulence of gonococci or spirochetes, but to the continuing violent social upheaval. Hunger for food is a cause of venereal disease just as much as sexual hunger. Evaluation of the relative importance of the many various etiologic influences depends upon intelligent application of perspective.

Furthermore, advancing scientific knowledge has demonstrated that health can no longer be defined as "that state of being existing in the absence of disease." Such is a sadly negativistic concept and is grossly inadequate today. Health is relative, never absolute. It is a positive phenomenon which may be tentatively defined as that state of being in which all the functional capacities, both mental and physical, are at their maximum effectiveness. If we look about us today we see that no one is truly and ideally healthy. Perfect health is an abstraction, an ideal, and though approachable like infinity, is probably unattainable. Some of us are merely less sick than others, just as some of us are more mature than others.

Looking further afield than our own small selves is difficult and discomforting. Thus we try to avoid it. Nevertheless, study beyond the narrow confines of specialized technics is necessary for the maintenance of perspective. The specialist has been defined as the man who knows more and more about less and less until ultimately he knows everything about nothing. There is a strong urge to stay confined within the narrow rut of routine; it seems so secure. But the security is only apparent and hardly worth the inevitable price of persistent deepening of the rut until it becomes indistinguishable from an intellectual grave. The world is critically sick. Mankind, having barely survived a catastrophic war, lies prostrate, starved and so desperately despondent that any new trauma may lead to virtual suicide of the species. Mental illness, whether individual or *en masse* is a medical problem just as much as more obvious epidemics of somatic disease. Panic is as contagious as smallpox. Yet treatment lies in the hands of those who have no knowledge of medical science, and appreciate it even less. The recent veto of the Science Foundation bill by President Truman is a case in point, revealing lack of perspective and failure to grasp the urgency of scientific research. Prime Minister Attlee's fresh demand that the British work harder and longer on less food reveals the need for education in the facts of medicine, for there are limits to human endurance. Statesmen who deal with human beings need guidance from physicians, whose training is directed toward an understanding of man as a living organism.

These are but a few of many possible examples emphasizing the urgent need for the medical profession to broaden the horizon of its vision and supply the leadership the Nation and the world needs so desperately. Because of lack of perspective and initiative, the physicians of the United States, and of Great Britain, Canada, Australia, and Europe as well, are now on the defensive against impending state-imposed plans for altering the methods of distribution of medical care. They have been barely consulted as regards the future programs of medical service, largely because practicing clinicians have shown little perspective vision.

Any and all problems must be viewed from three perspectives to be fully comprehended. First, we need to study the problem with the naked eye; secondly, we must apply magnification to its component parts and activities, and lastly, step far enough back so that it may be inspected through a telescope and thus related to its external environment. As medical students we all were taught that man lives in two environments: the external physical and social world, and the internal milieu of tissue juices, enzymatic activity, anabolism, and catabolism. Both environments are in a constant state of flux and kinetic adjustment. Both are significant to the unitary organism, man.

Translated into other terms, full comprehension of the potentialities of medicine involves three approaches: (1) the indivisible individual, psyche and soma as one, is the unit of study of clinical medicine; (2) magnification of the component parts, the biochemical reactions, electrical potentials, and cellular units which make up the individual are the concern of the biological sciences upon which clinical medicine depends for understanding the entity, man; and (3) man as a member of society, a unit of the external environment is the concern of social medicine. He is affected by other people, climate, housing, food, threats of disaster, and at the same time his behavior affects his environment. The well meaning fool who persists on going to work with an acute and contagious virus infection is a real menace to a community.

To understand man is the aim of every true physician. We cannot hope to comprehend fully the complexities of man without applying all three perspectives to the problem and utilizing every possible intellectual discipline in our analysis. Judgment comes from experience. Experience takes time and therefore judgment is one index of maturity of mind. Likewise, a broadening perspective is indicative of growing mental maturity.

Physicians more than other groups should recognize that today mankind the world over is sicker than at any time during the War. Ideals and hopes are crumbling everywhere. What good is length of life if there be no depth or breadth? It is so much easier to fight for our convictions than to live up to them. The need for courageous realism, perspective vision, scientific accuracy, and cold impartial logic, coupled with true intellectual honesty is more urgent today than ever before. Can the medical profession supply these characteristics? Not without a broader perspective. Without perspective the little appears big and the important may be ignored. Leadership is the duty and responsibility of those who think. Leadership is a privilege. Leadership is hazardous and painful. Presenting stark realistic truth to those many who live in their own dream world of egocentric wishful thinking is certain to elicit bitter and violent antagonism. Leadership requires conviction and courage, as well as ideas and ideals. Nevertheless, just because we as physicians are uniquely equipped in having a more comprehensive understanding of man than others, the burden of responsibility is logically ours. Are we ready to accept this privilege? Have we sufficient courage? Have we enough perspective? Are we, as individuals, mature enough?

Edward J. Stieglitz, M.D., F.A.C.P.

GASTRIC CANCER

Cancer ranks second only to cardiac disease as the most frequent cause of death in the United States. Of our 150,000 annual cancer deaths about 40,000 represent carcinoma of the stomach, the most common of all malignant neoplasms. In his recent review of the subject Wangensteen[1] emphasizes that the prevention of these deaths depends mainly on earlier detection of the disease. Fortunately the technic of surgical treatment of gastric cancer has improved to the extent that it carries little risk and affords the prospect of a high percentage of cures in suitable cases. Unfortunately, however, the number of suitable candidates for a curative type of operation is a small minority of the whole group.

We may look forward hopefully to the time when cancer will be largely preventable, when its diagnosis will be easy without reference to location, perhaps by means of a serologic test, and when it will be curable even after it is discovered late. It is entirely right that all available energy and money and other resources should be directed toward the accomplishment of these ideals. Nevertheless, it is important that we should not become so preoccupied with the future and its expectations that we neglect to attack fully the problem as it now exists. As stated before, in the case of carcinoma of the stomach, the main task is the use of means for detection of the disease early enough that curative surgery can be employed.

The first step in the solution of the problem requires the insurance that persons who are cancer-susceptible will be examined for the disease. In women over 40 and in men over 50 the incidence of cancer increases sharply, so that Wangensteen recommends that persons in these groups be examined 3 or 4 times a year. He favors the use of Cancer Detection Clinics for this purpose, mainly because this kind of facility can offer a range of expert attention. It is obvious, however, that the conscientious family physician can contribute largely to the program. It is rather apparent that any kind of plan for frequent examinations of supposedly normal persons depends upon appropriate education. There is little need to fear that the public will not coöperate. The majority of our citizens are all too willing to accept advice about their health and to act on it. Most of them too are able to distinguish good advice from bad. It is undeniably true that the practicing physicians individually have been anything but vigorous in establishing a satisfactory program of periodic health examinations for their patients. However, this situation is improving rapidly from year to year and needs only a little more attention from a great many physicians to become adequate.

The matter of technics to be employed at the time of examinations for cancer detection offers considerable difficulty. Certainly the routine history and physical examination are far from enough. As Wangensteen points out, the stomach like other hollow organs shows surprisingly little alteration of its function by incipient carcinoma except when bleeding occurs. As the best possible proof of this fact, he recalls that some of the foremost experts of all time in the field of gastric surgery have succumbed to carcinoma of the stomach because the disease did not produce symptoms until after it had passed the stage of being curable by gastric resection. Of course, X-ray examination of the stomach and the use of the gastroscope are remarkably reliable diagnostic methods. However, it is far from practical at present to recommend that every person over 40 should have these examinations several times a year. Nevertheless, simpler technics such as examination of the stool for occult blood, hemoglobin estimation, and detection of achlorhydria can be used routinely and should serve to point to the need for more elaborate diagnostic study.

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[1] Wangensteen, O. H.: J. A. M. A., 1947, 134, 1161.

It is quite certain that the full use of existing detection methods is not the final answer to the problem of carcinoma of the stomach. It is, however, the most hopeful approach now available and as such deserves the complete support of us all.

H. H. H.

In and Out of Focus

BY THE OBSERVER

The Annals Makes Progress

Being at a loss for material for this column, and finding writing painfully laborious, your Observer was happy to be relieved of most of his editorial duties early in the summer. How much his vacation will improve the quality and content of this column, readers will have to judge. In any event, the column again takes its place in the MEDICAL ANNALS in a more abbreviated form, thereby permitting the inclusion of new features.

While vacationing, your Observer studied the results of the survey of ANNALS readers made last October. It will be recalled that opinions and suggestions of readers with respect to the journal were sought. Among the latter were a number of proposals which appealed to your Observer. Upon his return home, he discussed them with the Editor, who approved the inclusion of two new departments, one devoted to hospitals and the other to questions and answers.

The ANNALS was fortunate in obtaining Mr. Karl H. York, Administrator of Arlington Hospital, as editor of the Hospital News section. Mr. York, an active member of the Hospital Council of the National Capital Area, is a writer of considerable experience, having been a frequent contributor to publications in the hospital field. He will gather items of medical interest from all hospitals in the Washington Metropolitan Area. They will include notes on medical staff programs, appointments to staffs, changes in hospital policy affecting physicians, and numerous problems confronting the hospitals. A special feature during the first year will be historical sketches of hospitals in the Washington area. They should provide physicians, especially the hundreds of practitioners who have recently arrived in Washington, with valuable information about the institutions in which they work.

The success of the department to be known as "Queries and Answers" will, of course, depend upon the interest shown by ANNALS readers.

Long before these lines appear, members of the Medical Society will have received a letter from the Editor announcing the initiation of this feature. Questions submitted by members may be of a scientific or general nature. However, they must be of general medical interest to readers and suitable for publication. As questions are received, they will be referred to specialists in the field to which they relate. Prompt replies will be sought so that questions and answers will appear as soon as possible after they are received. The Editor wishes it understood that he does not necessarily endorse the answers to questions, but readers are assured that they will be obtained from the best sources possible.

Within the limitations imposed upon the Annals, other features will be added as soon as it is found feasible. Incidentally, readers may have noted that changes have already been made in the appearance of the Annals in accordance with the wishes expressed by some of those who participated in the study.

It is perhaps unnecessary to point out the Editorial Board's sincere desire to provide Society members with the best possible journal. In this connection it might be mentioned that the functions of a state medical journal are quite different from those of other medical publications. First of all, such a journal should provide readers with the best scientific material obtainable. It is obligated, too, to deal with general problems confronting the medical profession, many of them at present being of a social and economic nature. Editorials, articles and reports are therefore published on these subjects. Dissemination of medical news is also an important function of a state medical journal.

How well the Annals succeeds in fulfilling its functions, only its readers can decide. Comments made by Society members have, on the whole, been most commendatory. Communications with respect to the Annals from Washington and various parts of the country have contained much praise for the Society's publication. These have been most heartening to a comparatively small editorial staff.

Anyone who is responsible for even a modest pamphlet can testify that its preparation is no small task. The Annals is an ambitious publication for an organization the size of the District Medical Society. It requires continuous effort by experienced personnel to get it out regularly. It is therefore pleasant for those who labor so diligently to improve its quality to know that many think well of their handiwork.

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Davidson Portrait Fund

Medical societies are frequently charged with being unappreciative of services rendered by loyal and interested members. Honors, it is pointed out, often go to physicians who have done nothing to earn the recognition of their organizations. Examples are cited to prove that occurrences of this kind are not the exception, but the rule.

To what extent this situation exists is debatable, but that it does exist cannot be denied. Anyone who has been closely associated with medical societies over a period of years can recall incidents of alleged injustice which were followed by charges of ingratitude. But happily there are many instances where recognition was given to those who served faithfully and well. These have been heart-warming occasions and it is to be regretted that they are not more frequent.

Our Medical Society, in common with other medical organizations, has not always been appreciative of its most faithful workers. But it is a pleasure to record that, on a number of occasions, it has shown its gratitude. Dr. Edward Young Davidson is an example in point. No one is more deserving than he of the honors which the Society has conferred upon him. For he has served the organization as few are privileged or willing to do. Unostentatiously, he has made real sacrifices, done much hard work, and adhered steadfastly to his purpose.

Some physicians stand out from their colleagues because of their scientific ability, others for their humanitarian qualities, and a few are builders. Dr. Davidson is certainly in the latter category. For many years his sound leadership in medical affairs did much to strengthen the Society's position in the Nation's Capital. But Dr. Davidson is more than a builder. He is also a capable physician and a humanitarian.

It is hardly necessary to state that if it had not been for Dr. Davidson's untiring zeal, the Medical Society would not be the proud possessor of its beautiful building on M Street. The building stands today as an imposing monument to Dr. Davidson and those who were closely associated with him. It is a surprisingly modern edifice, considering it was built more than a quarter of a century ago.

Since its erection, the building has been the center of medical activity in the District of Columbia. Here the world's greatest medical scientists have appeared. Many medical meetings of nation-wide significance have also been held in its auditorium. When members of the Society gather at the building, they may well reflect upon the fact that it was largely due to one man's vision and undaunted courage that the Society's home became a reality. Washington physicians in generations to come should not forget this man to whom they owe so much.

As older members know, Dr. Davidson has been honored by his fellows on other occasions. As a further demonstration of the Society's affection and high regard, it is now proposed to have a portrait painted of him and hung in the Society's building. At its meeting on June 23, 1947, the Executive Board authorized the creation of a Special Committee on the Davidson Portrait Fund. A letter has gone forward from this committee to the entire membership, informing them that contributions to the Fund will be welcome. The committee has set a maximum of $10 for any contribution. The reason is to encourage as many of Dr. Davidson's friends and members of the Society to participate as possible.

Members of the Special Committee are Dr. Coursen B. Conklin, *Chairman*, Dr. A. Magruder MacDonald, and Dr. Oscar B. Hunter.

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Quick Curtain!

Most physicians have been oblivious to the drama being enacted during the past few months in a small chamber tucked away in a corner of the Capitol Building. This is not too surprising because hearings of the Senate Subcommittee on Health and Education on the so-called Taft-Smith-Ball-Donnell health bill (S.545) and its opposite, the current version of the Wagner-Murray-Dingell bill (S.1320), although well attended, were seldom in the news. There were too many world-shaking events claiming the headlines.

Witnesses appearing before the Subcommittee were, for the most part, familiar figures. With few exceptions they had very little new to offer. An exception was a Washington physician, Dr. Maurice H. Friedman, whose exhaustive study of Selective Service statistics on the health of registrants made a deep impression upon both the Subcommittee and observers. An abstract of Dr. Friedman's testimony is published elsewhere in this issue of the ANNALS. Your Observer hopes that this material will be widely read by the medical profession, for it contains important and enlightening information.

Of all the witnesses, the one most eagerly awaited was Isidore S. Falk, Director of the Bureau of Research and Statistics in Social Security Administration. Here was the man who, it was charged by anti-New Dealers, was the architect of nearly all legislation providing for the establishment of a compulsory sickness insurance scheme in the country. The Republican-dominated Subcommittee had laid its plans to question Falk exhaustively, thereby bringing to light his true role and his qualifications for it.

Mr. Falk took the witness chair on a hot July morning. The small chamber was packed with those who anticipated an exciting session. Among them were officials of Social Security Administration, representatives of organizations favoring compulsory sickness insurance, and a sizable delegation representing organized medicine. Senator Forrest C. Donnell, Republican, of Missouri, Acting Chairman, began by questioning Falk concerning his early career in the health field. Falk, whatever his real feelings, seemed calm and replied to the questions directed at him in a soft, pleasant manner. However, he was cautious and at times evasive.

Senators Murray and Pepper took a hand when the going got rough for the witness. Senator Murray broke in with the statement that Mrs. Marjorie Shearon, Senator Donnell's adviser at the hearings, who some years ago had been on Falk's staff but is now bitterly opposed to him, had expressed views on health matters which were quite contrary to those which she now held.

Up to this point, the hearing had moved at a snail's pace, and the questioning of the witness by Senator Donnell did not seem to be getting anywhere. Finally it was proposed that memorandums prepared by Mrs. Shearon while she was with the Social Security Administration be read into the record. These Falk had brought with him.

However, at this point the proceedings were brought to a halt when Senator H. Alexander Smith of New Jersey, Chairman of the Subcommittee, announced that, noon having arrived, and the Senate being in session, permission would have to be granted by the Senate for the Subcommittee's hearing to continue. Apparently this was not agreeable to the Senate, and the Chairman announced that the hearings were over for this session. Thus came to an abrupt end Falk's appearance. In theatrical parlance, there had been a "quick curtain."

What did this mean? Of course the House and the Senate were preparing to adjourn, but was this the real reason for the sudden cessation of hearings until next year?

Mrs. Shearon said that the hearings were recessed because Falk "attempted to delay Senatorial questioning about his activities," and that "since several days would be required to examine Falk and the legislative calendar was crowded during the last week of this session of Congress, the Health Subcommittee decided to recess until January." On the other hand, Gerald G. Gross, Editor of the *Washington Report on the Medical Sciences*, said that the unofficial explanation was that Falk was found "to be too tough a witness to crack."

Be that as it may, the Congress is through with health legislation until its next session. Between acts there will be much more activity than in the past. For despite the little publicity which the recent hearings have received, health legislation is still a lively subject on the Hill. If some of the more pressing international and domestic problems are disposed of early in the next session, there is no doubt that greater public interest will be shown in health bills.

In the meantime, numerous bulletins issued by medical organizations and individuals will provide those who are interested with many lively sidelights on what is going on behind the scenes. This will certainly be true of Mrs. Shearon's legislative reports. She is not only unafraid to state her views on health matters, but has ready access to "inside information." Mr. Gross, who has long been an able science reporter for the *Washington Post*, will continue to have his say on the medical situation. His comprehensive and carefully prepared reports include many subjects unrelated to legislation and therefore are of value to a wide variety of readers. Bulletins issued by the American Medical Association, the United Public Health League, the National Physicians' Committee and the American Association of Physicians and Surgeons will undoubtedly be less frequent until the next Congress convenes.

Interesting and informative as this material is, the fact is that the health legislative situation is not so complex as it would appear. Proponents of compulsory sickness insurance schemes are known to all representatives of medical groups in Washington. So are their connections and activities. Proponents have the same knowledge of the opponents of such a system. Physicians should therefore not be led into the error of believing that followers of either group are necessarily Communists, New Dealers, left-wingers, conservatives, reactionaries, or obstructionists. If one excludes the Communists, each group has within its fold persons of varied political beliefs. It therefore behooves medical leaders to take a more objective view of health legislation, if they wish to increase their following of intelligent men and women.

Those who have followed the trend of this legislation realize that change in viewpoint has characterized both sides of the controversy. Senator Wagner and his supporters are steadily making concessions. On the other hand, the American Medical Association was looking at things quite differently when it gave tacit approval to the Taft health bill.

Before the curtain rises on the next act, the AMA should make a thorough study of all health legislation for the purpose of pointing out those things which it favors in its opponents' bills and those which it rejects. Equally important are sound reasons for its position. The time has arrived for a calm and thoughtful approach to health legislation.

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Veterans Administration and the Society

Recent termination of the agreement between the Medical Society and the Veterans Administration brought to a close a relationship which has existed only on paper. A brief review of the developments which led to the dissolution of the agreement will prove enlightening to our members and should set at rest any doubts which may exist.

In the midsummer of 1945, Major Spencer V. Meade, Chief Medical Officer of the Washington Regional Office of the Veterans Administration, wrote the Society that he had received a request from the Medical Director of the Administration "for information regarding any schedule of fees adopted by your organization or by any similar organization." The Administration, it was explained, wished this data before revising its schedule of medical fees then in effect. It appeared that a similar letter had been directed to other state medical organizations.

At that time Major Meade said there were adequate facilities in Washington for the medical care of veterans. Private practitioners would therefore not be called upon to render service for some time. However, he thought eventually veterans would come under the care of private physicians.

The Society was glad to comply with Major Meade's request and informed him that the Society would coöperate in every way possible. At the same time, conferences were held with other officials in the national office of the Administration. They were also assured of the Society's desire to be of all assistance possible.

Late in September 1945, Major Meade again met with the Society's Committee on Industrial Medicine. He stated that the situation in his office was serious, because he did not have a sufficient number of physicians to examine returning veterans, particularly those who were seeking pensions. There was a backlog of some thousand veterans and only 15 examinations could be made daily by the medical staff then employed. He had been authorized to request the Medical Society's aid in securing physicians who might be employed part-time.

The Committee acted promptly, submitting the following recommendations, with the approval of the Executive Board, to General Omar N. Bradley:

"1. That adequate office space be obtained immediately to be used as a clinic in which to examine veterans.

"2. In view of the shortage of physicians in the Veterans Administration, the Medical Society of the District of Columbia be requested to canvass its membership for physicians who are qualified to assist in making examinations at the Regional Office, and that these physicians be compensated at the rate of $6.50 per hour, this being what is paid physicians doing similar part-time work at the Chesapeake and Potomac Telephone Company.

"3. That a revised fee schedule be put into effect so that physicians in private practice will be adequately compensated for their services to veterans. The present schedule has been in effect for several years and fees for certain procedures are so low that they are unacceptable to physicians."

The Society was later informed by Dr. Paul R. Hawley, the Administration's Chief Medical Officer, that its proposals were acceptable. Thereupon the Society membership was canvassed, the needed volunteers being obtained with little difficulty.

Shortly thereafter, Major Meade informed the Society that the services of the volunteers would not be needed, the reason being that the Regional Office had found it possible to employ a sufficient number of practitioners for its needs.

In the meantime, the Committee on Industrial Medicine was proceeding with the preparation of a schedule of medical fees for services by private physicians to veterans. This schedule was forwarded to Dr. Hawley for his approval. He returned it with some changes which were considered by the newly created Committee on Medical Care of Veterans. The Committee gave its approval and recommended endorsement by the Executive Board. The Board advised Dr. Hawley that it would recommend adoption by the Society. The schedule, together with a formal agreement, similar to one entered into with other state medical societies, was presented at a meeting of the Society on October 23, 1946, and unanimously adopted.

The following provision—one of fourteen—in the agreement makes it clear that active participation of District physicians in the Administration's medical care program was contemplated.

"The Medical Society of the District of Columbia will request all of its members to participate in a state-wide program whereby physicians in private practice will render medical services (examinations, treatments and counsel) in such cases as may be authorized by the Veterans Administration."

Following the Society's approval of the agreement and schedule, a canvass of members was again undertaken. The response was prompt and satisfying.

Months passed, but nothing further was heard from the Administration. Finally a new schedule was submitted to the Society by the Administration and a renewal of the agreement which had been in effect for a year was received. The Secretary made inquiries and learned that early in the development of the District's medical care program for veterans, it had been decided to enlarge the clinic facilities of the Regional Office so that at no future time would the services of private physicians be required. This surprised him considerably and he made further inquiries to ascertain the facts. He talked with Dr. Hawley, who expressed some surprise that private physicians had never functioned under the agreement. He informed Dr. Hawley that he saw no reason for the renewal of the agreement in the light of what he had learned. He expressed surprise that any relationship had been entered into under the circumstances.

Under date of July 22, 1947, Dr. Hawley wrote that he found the Washington Regional Office "equipped in staff to meet its responsibilities and from the present outlook it is fully anticipated, that for the coming fiscal year, it is in a position to cope with the situation with its own staff. I agree with you that completing an agreement would be of no benefit to members of your District Medical Society."

In your Observer's opinion, there is one regrettable aspect of this matter, and that is that the Society went to considerable length to cooperate with the Veterans Administration when some officials of the Administration must have known that it was merely an idle gesture.

The Public Health Exhibit

An expanded lay educational program will be initiated by the Medical Society early in the fall. One of its new features will be the Public Health Exhibit, which will be on display during the 18th ANNUAL SCIENTIFIC ASSEMBLY at the Hotel Statler. The Exhibit is being sponsored jointly by the Society, District Health Department, District Chapter of the American Red Cross, District of Columbia Tuberculosis Association, and District of Columbia Division of the American Cancer Society. Exhibitors include most of the governmental and voluntary health agencies in or near the District of Columbia.

Although this type of exhibit is new to Washington, it has been presented elsewhere with great success. Those who attended the Century of Progress Exposition at Chicago some years ago will recall the splendid exhibit prepared under the direction of the late Dr. Eben J. Carey, Dean of the Marquette University School of Medicine. For some months prior to the Exposition, Dr. Carey toured the medical centers of Europe in search of material. The result was a memorable visualization of the development in medical science in the preceding hundred years.

Subsequently, Dr. Carey was instrumental in planning the Hall of Health, an ambitious health exhibit sponsored by the State Medical Society of Wisconsin, the Medical Society of Milwaukee County, and a number of official and voluntary health organizations in Wisconsin. It was first shown in the arena of Milwaukee's large Municipal Auditorium. Your Observer assisted with the initial exhibit which in one week attracted some 150,000 Milwaukee citizens.

If your Observer is not mistaken, this was a pioneer venture in so far as medical societies are concerned. Since that time, other medical organizations have undertaken projects of a similar nature with considerable success.

The Public Health Exhibit has been discussed with several leaders in the health field in the District of Columbia. They all agreed that it has limitless possibilities. One stated that there was no more effective method of health education than the visual method, and he hoped the Exhibit would become a permanent feature of the ASSEMBLY.

Its sponsors believe that the Exhibit's growth will be rapid and that in the near future it will be necessary to obtain more adequate facilities than are available at the Statler. There is a possibility that such a display may find a permanent home so that it can be viewed by the public throughout the year. Health museums in pre-Hitler Germany were of this type, and were without doubt the finest of their kind in the world. Of course, development of such an institution in Washington lies well in the future. The important thing now is to make the Public Health Exhibit superior to anything of its type shown in the Nation's Capital.

The committee in charge is exceedingly anxious to get off to a good start. Your Observer is familiar with the work of the committee and is confident that the public which sees the Exhibit will be most enthusiastic.

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A Landmark Vanishes

In no other city is the sentimental attachment of the people for national shrines more in evidence than in Washington. Thousands of citizens constantly throng the Nation's Capital not only to look upon imposing memorials but upon the homes of the great and the near-great. Few of the latter attract more visitors than the birthplaces of the illustrious in the country's history. There are not many of these in Washington, but several are to be found in nearby states.

Reflecting upon the interest of most Americans in the birthplaces of their great men and women, the realization came to your Observer that the time was not so very far distant when such shrines will no longer exist. Although thousands of babies continue to be born in homes, the percentage is rapidly decreasing. For the medical profession frowns upon the home as a birthplace. Modern obstetrics can best be practiced in the hospitals, and so hospital confinements are the rule. In the future, if admiring citizens wish to consecrate the birthplace of some great individual, they will have to seek out a hospital.

The first reaction to such a suggestion would probably be met with the protest that sentiment would be missing. Somehow, a home, be it modest or pretentious, has a warmth about it which is absent in an institution. On the other hand, the hospital approaches the home more closely than any other as a fitting place to perpetuate the birthplace of an individual. The more one thinks of the possibilities which this situation holds, the more one is impressed with the fact that herein lie great opportunities.

Memorials in hospitals are not uncommon. Rooms and sometimes buildings and equipment are purchased as memorials to some person or group. However, your Observer visualizes the participation of a far greater number of people in establishing such memorials than at present.

His suggestion to hospitals would be that they set aside an attractive room in their institutions where the memory of citizens who claim them as their birthplaces would be perpetuated by friends and admirers. Their names would be placed on a permanent "honor roll," perhaps a bronze plaque, such as commemorate the services of our veterans. This would best insure the "honor roll's" permanence. The inscribing of a name on the plaque might well be made an important occasion, at which the individual's contributions to society would be reviewed and perhaps endowments in support of the institution accepted.

Incidentally, the Memorial Room should be one in which the visitor would take esthetic satisfaction It should be free of the usual hospital atmosphere, and a pleasant place for small gatherings.

It would appear certain that the plan proposed would do much to stimulate public interest in and support of our voluntary hospitals, which are now so badly in need of assistance. However, your Observer had primarily in mind the perpetuation, in the hospitals where they were born, of the memory and birthplace of valuable citizens.

The birthplace of yesterday is vanishing, but from the standpoint of health, a new and a better one is taking its place, and perhaps at some future time there will attach to it some of the sentiment which we feel for the home.

T. W.

MEMBERSHIP

The following applicants for membership were duly elected to membership at the meeting of the Executive Board, August 25, 1947, in accord with Amendment XI, Section 2, of the Constitution and By-laws of the Society:

Active Members

Alejandro F. Castro, 3400 Garfield Street, N.W.
William P. Chalfant, Jr., 1915 16th Street, N.W.
John D. Foley, 1746 K Street, N.W.
Arnold S. Greenberg, 1925 Eye Street, N.W.
William L. Jamison, 2212 Eye Street, N.W.
Paul Sadler Kemp, Room 217, Union Station
Marvin H. Kendrick, 1835 Eye Street, N. W.
Wayne McFarland, 6856 Eastern Avenue, N.W.
Thornton T. Perry III, 1726 M Street, N.W.
Frank J. Sanzaro, 1835 Eye Street, N.W.
Francis J. Weber, 8001 Custer Road, Bethesda, Md.

Associate Members

Charles R. Brooke, 4114 Jenifer Street, N.W.
Fred R. Franzoni, Jr., 316 South Garfield Street, Arlington, Va.
Ben Calloway Jones, Jr., 814 Prince Street, Alexandria, Va.
Alma C. B. Kelly, 8237 Georgia Avenue, Silver Spring, Md.
George Macatee, Jr., 2205 California Street, N.W.
Paul A. McNally, S. J., 3900 Reservoir Road, N.W.

"THE ATTORNEY FOR THE DEFENSE"

WALTER E. VEST, M.D.

Editor, West Virginia Medical Journal

EDITOR'S NOTE: Dr. Vest has long been active in medical organization work. He is a writer of wide experience and ability. Any list of the best state medical publications must include the *West Virginia Medical Journal*. Dr. Vest's article reveals him as an ardent "defender of the faith."

At the Sunday religious service held during the AMA Centennial, Rabbi Liebman referred to the medical profession as "the attorney for the defense of mankind." His comparison is indeed descriptive and apt, and with it loom duties and obligations befitting the role. Let us consider some of these.

Whether we like it or no, the medical profession is unquestionably on trial at the bar of public opinion. To say that this is largely the result of propaganda emanating from political bureaucrats, professional social workers, politicians seeking to influence the unwary voter, and would be "lifter-uppers," the majority of them resident upon the Potomac and within the shadow of the Federal Capitol—sojourning only, we hope—is but to beg the question. True, this rather nondescript aggregation is the mainspring of the movement, but we must face the fact and meet the challenge. Otherwise we have to expect only socialization of our profession with a consequent fall in the level of medical service, medical education, and everything pertaining to health and medical care, to the mediocre level now prevalent in Europe. God forbid! Moreover, socialized medicine constitutes the keystone of the arch of Russian communism. Again God forbid!

We talk much of the public relations of our profession. Our organized medical bodies, especially the American Medical Association, should of course maintain proper public relations mechanisms. That will help, but we had as well understand and admit the fact that every mother's son among us is a personal public relations servant for the entire profession. The truth of this, once realized, should have a rather sobering effect upon the individual doctor.

If the physicians in the aggregate really constitute "the attorney for the defense of mankind," what are the outstanding duties incumbent upon us?

Our first duty, as we conceive it, is good service to our patients. This includes not only good scientific medical service, but a realization of the fact that we are treating a person and an individual rather than a "case" or a disease. The viewpoint of the patient should always be considered and time enough taken to explain to him his condition and what is necessary for his recovery. Time thus spent, and especially the maintenance of an air of friendliness at the time, will pay good dividends. Our patients should look upon us not only as physicians, but as friendly physicians.

Another duty is fair economic treatment of our clientele. The setting of adequate fees, and by adequate we mean adequate for both physician and patient, is one of the most difficult tasks which the physician must undertake. We should of course be sufficiently compensated for our services, but our fees should be set always with due consideration of the ability of the responsible party to pay. Moreover, there is room for legitimate difference of opinion as to fees. We are, however, of the opinion that it is better from the standpoint of public relations, both for the individual physician and the profession at large, to make errors in fees by undercharging rather than by overcharging.

A third duty devolving upon each physician, as we see it, is to be a full-fledged citizen of the community in which he resides. Too many of us live

Photo by Harris & Ewing

Officials of Medical Service and Group Hospitalization, Inc. signing agreement on June 24, 1947, whereby GHI agrees to administer the District Medical Society's new prepayment medical plan. Left to right, signing, Mr. Joseph H. Himes, President of GHI; Dr. Frank D. Costenbader, President of Medical Service; standing, Mr. Theodore Wiprud, Secretary of Medical Service; Dr. Walter A. Bloedorn, Secretary of GHI.

entirely within our medical shells rather than engage in all the civic activities which go to make up community life. We are citizens as well as physicians and should realize and accept our responsibility as such. One outstanding feature of this responsibility is the guidance of community thinking as to health, sanitation, health education, and the necessity of sufficient appropriations of public funds for the proper conduct of public health work and the efficient care of the indigent and the medically indigent. No other segment of our population has the knowledge and training requisite for performing this function adequately. And under this category we would list political activity of a nonpartisan nature, which should include proper appreciation and support of those members of the Congress of both political parties who have supported our cause and to whom we really owe the fact that we are not today regimented slaves of a political bureaucracy.

A fourth duty is a proper comprehension of the fact that we are members of one of the highest callings anyone can engage in, if not in fact the highest. We touch the life of our community and the lives of its citizens certainly as intimately as does the clergyman, the barrister, or the schoolmaster. When one enters a profession, by that act he automatically subscribes to the duties and the ethics of the calling he chooses. Hence the physician should ever keep in mind the ethics of medicine and conduct himself befittingly as a member of the profession which is more careful in choosing recruits to its ranks than any other. Moreover, he should be always mindful that it is a definite honor to be admitted to the profession of medicine.

Still another duty incumbent upon the physician is to work. Medicine is a humanitarian profession featuring self-sacrifice and altruism, and work is a necessary corollary to such a calling. The sluggard and the slothful have no place in any of the healing arts.

One more duty, continuing education, and we end our homily. Medicine is truly dynamic, improving and increasing in stature all the time. Descartes wrote generations ago: "If ever the human race is raised to its highest practicable level intellectually, morally and physically, the science of medicine will perform that service." Such being our objective, we must, if we accomplish our mission, study continually to keep in the forefront of our profession. The physician must be a student as well as a worker, else his labors will soon become

(*Continued on page 532*)

STATISTICS AND THE NATION'S HEALTH*

MAURICE H. FRIEDMAN, M.D.

Washington

EDITOR'S NOTE: Dr. Friedman's testimony before the Senate Subcommittee on Health and Public Welfare has attracted nationwide attention. Presented here is only a small portion of his testimony, which was so extensive that publication of all the material in the MEDICAL ANNALS was not possible.

Dr. Friedman has made it clear in his public utterances that he is in favor of experimentation with voluntary medical plans but is strongly opposed to compulsory sickness insurance.

The proponents of the two bills now before Congress (S.545 and S.1320) start out with two different basic assumptions. The sponsors of S.1320 have assumed that the status of this Nation's health is in such state that there is great urgency to cover the entire country with some improved form of medical care. Those persons who sponsor S.545, on the other hand, proceed on the assumption that there is no great urgency, and that we have time for further wise and cautious experimentation which will finally point the way to a wise public policy.

My testimony for the moment will deal primarily with the question of whether or not the situation confronting us is really so urgent.

Probably no point has been stressed more by the proponents of compulsory sickness insurance than the country-wide rejections by the Selective Service System. According to Senate reprint no. 4 (79th Congress) prepared under the direction of I. S. Falk, "one half to two thirds of the defects could have been prevented or rehabilitated with timely care." To the best of my ability I have made an analysis of the draft rejection statistics, and by bending over backwards have found that only 18 to 20 per cent of all rejections were for causes which could have been influenced by medical care. In order to reach these figures of 18 to 20 per cent we must make the following assumptions: (1) that every person with a defect could have been induced to seek medical attention; (2) that in every case the physician would have recommended some kind of corrective measure, including major surgery; (3) that every patient would accept the recommendations and agree to the corrective measures; and (4) that in every case the recommended measures would have been 100 per cent successful. Such assumptions, of course, are not consonant with our everyday experience.

The proponents of S.1320 have laid particular emphasis on the higher rejection rates for the Negro as compared with white registrants. They have implied that these higher rejection rates for the Negro reflect the lower economic status and the fact that a large proportion of the Negro registrants were from the rural South. Indeed, according to Senate Reprint No. 4, "these differentials leave no doubt that these rates were as high as they were because of past medical neglect."

An examination of the original data of the Selective Service System reveals that syphilis, mental deficiency and mental disease accounted for about 60 per cent of all rejections of Negroes. We may note that the rejection rate for cardiovascular disease is somewhat higher in the Negro than in the white man, but the Selective Service System was careful to point out that the reason for this difference was almost entirely due to the relatively high incidence of hypertension in the Negro. With the exception of educational deficiencies, venereal disease, and hypertension, the Selective Service statistics show that for every condition listed the rejection rate for the Negro was significantly lower than for the white man. You may find these data reproduced in table 7 of my complete manuscript (introduced into the record in toto). I wish to call attention particularly to those defects which are amenable to medical or dental treatment. For example, under "teeth" there were 125 white men with defects for every 1,000 men examined, compared with 47 per thousand for the Negro. Under "nose" there were 30 with defects per thousand in the white registrants, and 6 with defects for every 1,000 colored registrants examined. Under hernia the rates were 52 for the white man and 40 for the Negro, and under hemorrhoids, 11.6 against 9.9. Of every 1,000 white men examined, tuberculosis was found in 19.9 in contrast with 14.6 for every 1,000 Negroes.

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* Abstract of testimony before the Senate Subcommittee on Health and Public Welfare, June 25, 1947.

I am not using these statistics in an attempt to show that the Negro is healthier than the white man. But if we were to use the same kind of logic as that employed by the proponents of S.1320 we would conclude that the Negro is getting better medical care than the white man. That conclusion, of course, is not defensible. The chief point I wish to make is that the listing of the defects in the Selective Service System statistics has very little bearing on the status of our National health. These statistics do not indicate the kind of medical care available to the rejectees and have no place in any honest discussion about the need for medical care.

We have been deluged with statements that there is a very real economic barrier to medical care in this country. The claim has been made that the medical care a family receives is largely, if not wholly, dependent upon the family income. It has also been claimed that the incidence of illness is highest in the lower income brackets, so that those who need the most medical care get the least. The available data do not support these contentions.

According to Falk, Klem and Sinai[1] the incidence of illness is lowest in the lowest income group and rises progressively with each increment of family income to be highest in the highest income group. We may also note from the data of these same authors that 47 per cent of our entire population go through a year without any illness. Hence, when the proponents of S.1320 say that 40 per cent of our population go without any medical care in one year, they should also admit that the number of people who go without medical care is less than the number who report no illness for the year.

You may wonder why, even in Dr. Falk's data, the incidence of illness should be higher in the high income groups. There is one very important factor which has never been appreciated in all of these discussions. As a man works honestly and industriously his earning capacity increases with the passage of time. In the population surveyed by Falk and his co-workers the higher income groups contained many more older people than the lower income groups. Indeed, in the highest income bracket the number of persons over 45 years of age was more than twice as great as in the lowest income bracket. When we consider that the diseases which maim and kill are much more frequent in the older age groups the importance of this point becomes strikingly apparent.

TABLE 1*

The Volume of Medical Services Received by Individuals in Families of Stated Incomes—Expressed as Per cent of Volume of Lowest Income Group

Service	Family Income					
	Under $1200	$1200 to $2000	$2000 to $3000	$3000 to $5000	$5000 to $10,000	Over $10,000
Doctor's Calls	100	105	119	156	188	245
Dental Care	100	155	210	260	378	525
Hospital Days	100	72	82	65	90	129
Health Examinations	100	82	82	100	280	1,100
Immunizations	100	71	74	87	121	175

* Table 17 of complete manuscript.

When we consider the volume of medical care given in 1929 as reported by the Committee on the Costs of Medical Care,[2] some equally strange facts come to light. In table 1 I have calculated the volume of care in each category as the per cent of the volume received by the lowest income group. You will note there is a progressive and steady rise of dental services with each increment in family income, so that people earning $2,000 to $3,000 per year received more than twice as much dental care as the people who earned less than $1,200 per year. On the other hand, if you look at doctors' calls, the people in the $2,000 to $3,000 bracket received only 20 per cent more care than the people in the less than $1,200 per year bracket. With respect to hospital care there is no correlation whatsoever between family income and volume of care. The lowest income group received more hospital care than any income group until an income of $10,000 per year was reached. The same lack of correlation between volume of service and family income was noted in health examinations and immunizations.

If all aspects of medical care were dominated by the economic factor, and if all services were equally affected by the economic factor, we should expect that the volume of each kind of medical service would rise progressively with income, and the rising curve for each kind of service would parallel that for every other kind of medical service. We have seen that this is not true. The curves relating to volume of services and family income are not parallel—they vary independently of each other. We must therefore conclude that if there is an economic barrier to medical care, the economic factor does not affect all types of medical services equally. We must also conclude that other factors are operative in the distribution of medical care which equal or exceed in importance the economic factor.

We have seen in Senate Reprint no. 4 the statement that "37 per cent of all illnesses, disabling and nondisabling, reported by families with less than $1,200 per year family income were unattended." This statement, more than any other, carries the innuendo of widespread medical neglect. But what are these unattended illnesses? Again I should like to cite the work of I. S. Falk and his collaborators.[1] According to these workers one definition of an illness is "any condition for which 50 cents or more were spent on drugs." Of all illnesses cited 47 per cent were not disabling, i.e., did not interfere with usual activities of work, school, or play. Eight per cent were disabling in that sense but did not require the afflicted person to go to bed. In other words, about half of all the recorded illnesses allowed the patient to be up and around and did not interfere with his usual activities. Forty per cent of the "illnesses" were minor respiratory episodes or minor gastrointestinal upsets. Is it any wonder that 37 per cent of the illnesses were "unattended"?

Although we have been blessed with riches beyond those of other nations our national resources are not unlimited. We cannot afford to dissipate our energies on every minor problem. There are major problems which face us. These problems are concerned with those diseases which kill, such as heart disease, cancer, nephritis, vascular disease, and tuberculosis, and those diseases which maim: mental disease, tuberculosis, vascular disease, etc. You may note that the same diseases appear in both groups. To the extent that infection plays a role in some of these diseases (pneumonia, tuberculosis, and some forms of heart disease), housing, density of population, state of nutrition, and personal and public hygiene are of great importance. Twenty to 40 per cent of all heart disease, depending upon the geography, is due to rheumatic fever. It has been estimated that 1 per cent of all school children have rheumatic heart disease. Medical care alone will not be of much value in this problem. Medical care will enable the stricken individuals to lead more nearly normal lives and perhaps extend their life span, but no amount of medical care can prevent rheumatic heart disease. At this moment in medical history we do not have the means of prevention.

Mental disease is listed by the National Health Survey as the leading cause for prolonged disability. It is appropriate in this connection to cite the work of Hyde and his coworkers[3, 4, 5] on the socioeconomic factors

Calendar of Meetings

July	1	Graduate Nurses' Association
July	9	Subcommittee on Public Health Exhibit, 18th Annual Scientific Assembly
July	24	Section on Anesthesiology
July	25	Board of Censors
July	29	Committee on Industrial Medicine
July	30	Subcommittee on Scientific Exhibit, A.S.A.
July	31	Executive Committee, Washington Metropolitan Health Council
August	1	Subcommittee on Motion Picture Exhibit, A.S.A.
August	19	Cancer Control Committee
August	25	Executive Board
August	26	Program Committee
August	28	Graduate Nurses' Association

of this type of disease. With respect to mental deficiency the grade of the community (economic level, educational and recreational facilities, etc.) was the most important factor. The cultural or ethnic background was almost as important (mental deficiency was almost nonexistent in the Irish and the Jews regardless of the type of community). Population density was of no importance. The community grade seemed to have no effect on the incidence of chronic alcoholism, but density of population was the most important factor, along with cultural, ethnic, and religious background (chronic alcoholism being rare among Jews and almost nonexistent in the Chinese). With respect to psychoneurosis, which includes a very large proportion of the cases of mental disease, population density had little influence. But ethnic background and community grade were of great importance. This is no place for the detailed examination of the causes of mental disease, but I do wish to point out that the frequency of one type or another of mental disease is not simply a reflection of the presence or absence of medical care.

I think we should reëxamine the place of the physician in the community. I think we could expand to infinity our medical facilities without influencing significantly the incidence of many of our leading causes of death or disability. The physicians are not responsible for our present housing conditions. Nor are they responsible for the inadequate educational facilities in many of our states. Neither by the administration of pills from a little bottle, by universal inoculations, by X-ray therapy, by the use of radioactive elements nor any fancy gadgets can your physicians quickly, cheaply, and effectively erase the consequences of illiteracy, overcrowding, undernutrition, inadequate plumbing, and the widespread neglect of personal and public hygiene. The medical profession alone cannot shield the entire population from the effects of economic maladjustments.

BIBLIOGRAPHY

1. Falk, I. S., Klem, M. C., and Sinai, N.: The Incidence of Illness and the Receipt and Costs of Medical Care among Representative Families. Chicago: Univ. Chicago Press, 1933.
2. Committee on the Costs of Medical Care: Medical Care for the American People. Chicago: Univ. Chicago Press, 1933.
3. Hyde, R. W., and Kingsley, L. V.: Studies in medical sociology; relation of mental disorders to community socioeconomic level. New England J. Med., 1944, 231, 543.
4. Hyde R. W., and Kingsley, L. V.: Studies in medical sociology; relation of mental disorders to population density. Ibid., 1944, 231, 571.
5. Hyde, R. W., and Chisholm, R. M.: Studies in medical sociology; relation of mental disorders to race and nationality. Ibid., 1944, 231, 612.

MEETINGS

Monday, Tuesday, Wednesday, October 6, 7 and 8

18th Annual Scientific Assembly

See program elsewhere in this issue.

Wednesday, October 22

Davidson Lecture

Speaker and subject to be announced.

Wednesday, October 29

The Washington Heart Association will sponsor the program. Speakers and subjects to be announced.

Washington Physicians of Yesterday

SAMUEL SHUGERT ADAMS, A.B., A.M., M.D.

Dr. Samuel Shugert Adams was born July 12, 1853, in Washington, D. C. From the University of West Virginia he received the degree of A.B. in 1875, and of A.M. in 1878. He graduated with honors as M.D. from the Georgetown University School of Medicine in 1879. Thereafter for the remainder of his life he was a prominent and distinguished practitioner of medicine in Washington, specializing in diseases of children. He was attending physician in Children's Hospital, Georgetown University Hospital, and other hospitals in Washington.

He was a pioneer and leader in pediatrics, both local and national, and won national recognition in that field. Immediately after his graduation in medicine he was appointed Lecturer on Diseases of Children in the Georgetown Medical School, and he served as Lecturer and Professor of this subject from 1879 to 1916. He was also Professor of Medicine in that school from 1898 until his death. He was one of the founders of the American Pediatric Society, organized in Washington in 1888, and served as its President in 1897, and its Secretary for 25 years (1891–1916).

Dr. Adams was an exceedingly active member of the local medical organizations. He became a member of the District Medical Association in 1879, and was its Treasurer 1884–1895, and its President 1900–01. He joined the Medical Society in 1880, and was its Recording Secretary 1887–98, and President 1902. Secretarial work seemed to

(Continued on page 532)

News and Personals

The Fourth International Congresses on Tropical Medicine and Malaria will convene in Washington, May 10 to 18, 1948. Over sixty nations have been invited to send official delegates to these meetings, which are being held in the Western Hemisphere for the first time.

The Department of State, which is sponsoring the Congresses, has secured the assistance of five interested governmental agencies and fifteen scientific and professional societies, of which the Medical Society of the District of Columbia is one. Dr. William L. Howell is the Society's representative on the Organizing Committee.

Membership in the Congresses is open to physicians, scientists, and other professional persons qualified in tropical medicine. Students, nonprofessional persons interested in tropical medicine, and members of the families of professional members may enroll as Associates, but will not have the privilege of taking part in discussions or voting. The preliminary announcement and advance registration form may be obtained by writing to the Executive Secretary, Fourth International Congresses on Tropical Medicine and Malaria, Department of State, Washington 25, D. C.

The Georgetown University School of Medicine will sponsor three graduate courses for practitioners in Cardiovascular Disease, Electrocardiography, and Recent Advances in General Medicine, beginning October 2, 1947 and continuing through January 22, 1948. Detailed information is given on page ix of this issue of the ANNALS.

The Georgetown University Medical Center will sponsor an intensive graduate course in Otorhinolaryngology-Bronchoscopy by Professor Georges Portmann of the University of Bordeaux, France, for a period of two weeks, beginning May 24, 1948. Inquiries should be addressed to Dr. James A. Flynn, 1511 Rhode Island Avenue, N. W., Washington 5, D. C.

The Council on Medical Education and Hospitals of the American Medical Association together with the **Association of American Medical Colleges** is making plans for the comprehensive survey of medical education recently authorized by the AMA's Board of Trustees. A temporary planning committee, consisting of three representatives of each group, met in Chicago, September 6–7, to proceed with the organization of the survey. **Dr. Walter A. Bloedorn** was among the three who represented the Association of American Medical Colleges at the meeting.

Two new committees were created by the **Executive Board** at its meeting, June 23, the **Committee on Rehabilitation** and a special **Committee on Ophthalmology.** The latter committee was charged with the primary duty of considering legislative matters in the field of ophthalmology. Members appointed to the committee were: Dr. Richard W. Wilkinson, *Chairman;* Drs. Joseph Dessoff, Inez E. Wilber, Thomas A. Egan and James N. Greear, Jr.

Medical films produced by the United States Army are available on a loan basis and may be obtained by writing to the Chief of the Division of Training and Education, Office of the Surgeon General, War Department, Pentagon Building, Washington 25, D. C.

The new Georgetown University Hospital accepted its first patients, a group of 29 who were moved from the old hospital, on July 31. A brief ceremony marked the event. Included in the group was Dr. George Tully Vaughan, formerly Chief Surgeon of the University Hospital and Professor Emeritus of Georgetown University. New patients were admitted to the Hospital on August 1.

The new Hospital, which is operated by the Sisters of Charity of Nazareth, Kentucky, contains 407 beds and 123 bassinets. Other features include a two-table emergency room, 8 main and 4 minor operating rooms, and 6 delivery and labor rooms. It will be dedicated formally in the fall.

Invitations were extended to members of the Medical Society of the District of Columbia and friends to inspect the new building on August 14; many availed themselves of the opportunity.

The old hospital building will be converted into dormitory space and possibly classrooms.

New appointments to the faculty of **George Washington University** include the following physicians for the School of Medicine: Dr. Leon Richardson Culbertson, Clinical Instructor in Urology; Dr. John Edward Morris, Clinical Instructor in Medicine; Dr. Joseph Beinstein, Assistant Clinical Professor of Medicine; Dr. Charles Waters Thompson, Clinical Instructor in Medicine; Dr. Sol Katz, Adjunct Clinical Professor in Medicine; Dr. Peter D. Comanduras, Assistant Clinical Professor in Medicine.

Dr. Robert Morris, of the staff of St. Elizabeths Hospital, has been appointed head of the **Montgomery County Mental Hygiene Clinic,** effective October 1. He will succeed Dr. Mabel G. Wilkin of Woodhaven, Md., who has resigned. Dr. Morris has been associated with the County Clinic on a part-time basis for the past year.

A new information center to aid alcoholics has been opened on the third floor of 1713 M Street, N.W., by the National Committee on Alcoholism, which operates similar centers in other cities under the sponsorship of the Yale Plan for Alcohol Studies. Mrs. Jane Williams is Director and counsellor of the center. The new center is operated in coöperation with Alcoholics Anonymous and the District Health Department clinic. The telephone number is Republic 6522.

The Medical Arts Society of the District of Columbia has reorganized and elected the following officers to serve during 1947–48:

Dr. John A. Reisinger, *President*; Dr. Thomas Bradley, *Vice President*; Dr. T. Frasier Williams, *Secretary-Treasurer.*

In response to a request from the **Jewish Community Center,** Dr. Walter R. Stokes, Chairman of the Medical Society's Committee on Public Relations, has arranged for ten physicians to speak at the Center before groups during the fall and winter months. The talks scheduled are as follows:

October 28—"That Heart of Yours," Dr. Leslie French
November 11—"Acute Infections in the Aged," Dr. Joseph H. Cowan
November 25—"Cancer of the Skin," Dr. Frank J. Eichenlaub
December 9—"Care of Fractures," Dr. Leonard Peterson
January 6—"Acute Surgical Abdomen," Dr. Daniel L. Borden
January 20—"Important Diseases Peculiar to Women," Dr. Carlton N. Price
February 3—"Rheumatic Disease in Children," Dr. William F. Burdick
February 17—"Preparation for Motherhood," Dr. Samuel Dodek
March 2—"The Common Contagious Diseases," Dr. Harold F. McCann
March 16—"A Health Program for the Individual," Dr. Herbert H. Diamond

Dr. J. Winthrop Peabody will be one of the instructors during the Second Annual Postgraduate Course in Diseases of the Chest, sponsored by the American College of Chest Physicians, to be held in the Municipal Tuberculosis Sanitarium in Chicago, September 15–20, 1947.

Dr. Claude Moore will address the Society of Registered X-ray Technicians of Washington at its next regular monthly meeting, October 14, at 8 p.m. Members of the Society are welcome to attend this meeting.

Dr. John B. Nichols was recently the subject of a feature article in *Acacia Clarion*, official organ of the Acacia Mutual Life Insurance Company, on the anniversary of his 45th year of service with the Company. On August 1, 1902, Dr. Nichols was appointed Medical Director, a position he held until 1939, when the Board of Directors, "in recognition of his great contributions to Acacia," made him Advisory Medical Director, a position he still holds.

Dr. Robert H. Lowry, formerly surgeon of the Military District of Washington, has been appointed Chief Medical Officer of the Washington Regional office of the Veterans Administration, succeeding Dr. Spencer V. Meade.

Dr. Lowry, a graduate of Rush Medical College, joined the Army Medical Corps in 1917, and served during both World Wars. He retired from the Army with the rank of Colonel.

Dr. Daniel F. Lynch was elected trustee of the Fourth District of the American Dental Association at the recent meeting of the House of Delegates in Boston. Dr. Lynch is an Associate member of the District Medical Society.

Dr. Francis J. Fabrizio, Editor of the *Journal of the District of Columbia Dental Society*, was elected Vice President of the American Association of Dental Editors during the ADA Convention.

Dr. Luther Sheldon, Jr., who retired from the U. S. Navy in August 1946 with the rank of Rear Admiral, has been appointed associate physician of George Washington University. Dr. Sheldon is a graduate of the University of Michigan School of Medicine. At the time of his retirement he was Assistant Chief of the Bureau of Medicine and Surgery.

Dr. John W. Cronin, Director of Employe Health Division, Bureau of Medical Service, USPHS, addressed members of the Women's National Democratic Club, July 21. Dr. Cronin discussed the Employe Health Bill, Public Law 658, recently passed by Congress, which authorizes heads of Federal departments to establish health programs for their employes with funds appropriated by Congress.

Dr. Julius Schreiber, Director of the National Institute of Social Relations, has been appointed to the National Committee for Mental Hygiene. Dr. Schreiber was formerly consultant psychiatrist of the National Jewish Welfare Board. During the War he served as Lieutenant Colonel in the Army Medical Corps.

Dr. Leopold E. Wexberg discussed "Sex Delinquency" over WTOP, July 21. Dr. Wexberg is Director of the District Bureau of Mental Hygiene.

Drs. John J. Andrina and William E. Bageant are assisting on the programs of Professional Staff Proceedings at Walter Reed General Hospital.

CORRESPONDENCE

Washington, D. C., July 25, 1947

To the Editor
Medical Annals
Washington, D. C.

Dear Sir:

On September 8, 1947, a refresher course for the Undergraduate and Practical Nurses Association will begin at Central High School and will continue until June, 1948. The following doctors have agreed to conduct the course:

Topic	*Name*	*Date*
Anatomy and Physiology	Dr. James A. Gannon	September 8, 15
Internal Medicine	Drs. J. Lawn and Charles W. Thompson	September 22, 29; October 6, 13, 20, 27
Surgery	Dr. Philip A. Caulfield and Associate	November 3, 10, 17, 24, 31; December 1
Gynecology	Dr. Wm. J. Cusack	December 8, 15
X-ray	Dr. Eugene J. McDonald	December 22, 29
Obstetrics	Dr. J. Bay Jacobs	January 5, 12
Gastrointestinal Diseases	Dr. Roy L. Sexton and Associate	January 19, 26; February 2
Genitourinary Diseases	Dr. Alfred H. Benson	February 9, 16
Children's Diseases	Dr. P. A. McLendon and Associate	February 23; March 1, 8, 15, 22, 29
Allergic Diseases	Dr. Alvin Seltzer	April 5, 12
Ear, Nose and Throat	Dr. David Davis	April 19, 26
Skin Diseases	Dr. Frank J. Eichenlaub	May 3, 10
	Dr. Raymond A. Osbourn	
Eye Diseases	Dr. Wm. D. Foote	May 17
Fractures	Dr. Edward P. Larkin	
	Dr. Robert C. Rush	May 24, 31
Syphilis	Dr. Russell J. Fields	June 7, 14
Chest Diseases	Dr. Edgar W. Davis	June 21, 28

These doctors are conscious of the need for improving the preparation for practical nursing in the home. They are showing their interest and concern in a practical manner.

There are upwards of twelve hundred undergraduate practical nurses in the District of Columbia. This army contains all sorts of recruits. The scale includes well-informed, high-type, and very satisfactory people. It also includes alcoholics, drug addicts, and undesirable

AMERICAN COLLEGE OF CHEST PHYSICIANS

The Potomac Chapter of the American College of Chest Physicians will meet in the District of Columbia Medical Society Building at 1718 M Street, N.W., on Sunday, October 5, 1947, at 1:00 p.m.

Registration for this meeting will begin at 1:00 p.m. The scientific program will start at 2:00 p.m.

The program is as follows (although the order of papers may be changed):

"Recent Trends in the Surgical Therapy of Pulmonary Tuberculosis."
Herbert C. Maier, M.D., Assistant Professor of Thoracic Surgery, New York University, and Associate in Surgery, Columbia University, New York City

"Etiology of Hemoptysis Associated with a Negative Plain Chest X-ray."
Osler A. Abbott, M.D., Assistant Professor of Surgery and Chief of the Division of Thoracic Surgery, Emory University Medical School, Atlanta, Georgia

"The Role of Inhalation Therapy in the Management of Bronchiectasis."
Arthur M. Olsen, M.D., Consultant in Medicine, Mayo Clinic, Rochester, Minnesota; Assistant Professor, Mayo Foundation, University of Minnesota

"Postmortem Pneumothorax."
David Salkin, M.D., Clinical Director, Hopemont Sanitarium, Hopemont, West Virginia; Assistant Professor of Medicine, University of West Virginia School of Medicine, Morgantown, West Virginia

"The Cytology of Bronchial Secretions in Carcinoma of the Lung."
Peter A. Herbut, M.D., Assistant Professor of Pathology, Jefferson Medical College, Philadelphia, Pennsylvania

Following the scientific program there will be a short business meeting at 5:15 p.m. A cocktail party will be held at the Mayflower Hotel at 6:00 p.m., followed by dinner at 6:30.

An X-ray conference, at which interesting X-ray films will be presented, will be held at 8:00 p.m. at the Mayflower Hotel.

Edgar W. Davis, M.D.
Chairman, Program Committee

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citizens. Practical nurses are not licensed, registered, or otherwise controlled. Anyone can say that she is a practical nurse and can charge your patient more than the graduate nurse is allowed. Some commercial agencies will place their names on the list without thorough investigation provided that the candidate sign an agreement to hand over to the registry ten per cent of all her meager earnings from then on, regardless of how her future work comes to her. Practical nursing, then, is not held in high repute by many people. That is why the Association of Undergraduate and Practical Nurses of the District of Columbia was formed about two years ago. It was formed to raise the status of practical nursing, to provide examination, licensing, registration, and regulation of all practical nurses. When the Association was formed several of the agencies notified their nurse clients that if they joined the Association they would be boycotted by the registry, thus cutting off their means of livelihood. In spite of this about a hundred undergraduate and practical nurses joined the Association and the battle to improve their calling.

In conjunction with the Graduate Nurses' Association the Undergraduate Nurses' Association prepared a bill for action by Congress which would provide a competent and reliable practical nursing service for Washington. This bill is before the Commissioners at this time and has not received their endorsement because the Commissioners are not convinced that there is sufficient public sentiment in favor of such a measure. I am sure there is such sentiment, but it needs vocalization. If you think so too, won't you write a letter to your favorite newspaper and also the Honorable Commissioners and express your views?

Fortunately, there is now a Practical Nurses Registry which can be recommended with the knowledge that no nurse will be sent out who has not been thoroughly investigated and who has not met the requirements of the Association. It is called the Association of Undergraduate and Practical Nurses Registry, and it is located at 4839 Wisconsin Avenue, N.W. (Please now take your ballbearing pen which writes under water and put their telephone number down where you can find it the next time you need an undergraduate nurse. The phone number is Woodley 3226.)

The practical nurse is supplanting the graduate nurse in the home because most graduates are no longer interested in the humdrum of ordinary bedside nursing. Doctors must have dependable assistants to help them care for the sick. The passage of this bill will secure these assistants for them. The Medical Society should use its influence to persuade all hospitals to make plans for a one- or two-year course for practical nurses. The experience during World War II with the Red Cross Nurses' Aides proves that instruction and training of undergraduates really assists in the education of graduate nurses because it conserves their time for more important work.

I'm sure that the Medical Society is grateful to the physicians who have consented to give this refresher course to the Association of Undergraduate and Practical Nurses because it will improve their work and be of great benefit to the people of Washington.

Very truly yours,
James A. Gannon, M.D., F.A.C.S.

Washington, D. C.

To the Editor:

The papers of Drs. Gannon and Lahey and the answer of Esther Odegard, R.N. (Medical Annals, July 1947) make interesting reading.

To one who is more or less on the sidelines it seems that Miss Odegard fails to meet the issue presented.

No one contends that the educational requirements for R.N.'s need be tampered with. It seems to me the nub of the situation is that the R.N. needs help for the less highly specialized parts of her work.

The medical profession long since has met this need in its service to the public. We have laboratory technicians, X-ray technicians, physiotherapy aides, and social service workers to take over much of the medical work, formerly done exclusively by physicians. Presumably the public benefits by this through lower costs and more efficient service, as physicians would have to charge much more if all this work were done by the medical profession. Indeed there are not enough physicians to do all of this work.

Now the time has come for the nursing profession to face the same situation. There are not enough R.N.'s to go around; there is too much "scut work" to be done by highly trained women and they need help to save their trained faculties for more specialized procedures.

Some such answer as that proposed by Dr. Gannon seems therefore to be only common sense.

Frank J. Eichenlaub, M.D.

BOOK REVIEW

Surgical Pathology, 6th ed. William Boyd, M. D., Dipl. Psych., M.R.C.P. Ed., F.R.C.P. Lond., LL.D, Sask., M.D. Oslo, F.R.S.C., Professor of Pathology. The University of Toronto, Canada. Price, $10.00. Pp. 858, with 530 illustrations, including 22 color figures. Philadelphia: Saunders, 1947.

The sixth edition is very similar to the fifth, although additions have been made, some of which will be specified below. The illustrations are very good, and in this edition the author has changed a few, added a few, and taken out an occasional one.

This book is written for the surgeon as well as the pathologist and the author has attempted to impress upon the reader the importance of the proper relationship between the two. The subject matter is limited to the portion of pathology which is of interest to the surgeon.

In bringing the book up to date he has included some new material such as tumors of the larynx, pinealoma, Bittner's milk factor in relation to breast carcinoma, avitaminosis in cancer of the mouth, the Papanicolaou vaginal smear method in diagnosing carcinoma of the cervix, fibrous dysplasia of bone, inflammatory nodules of muscle in chronic arthritis and fibrositis of the back. Worthy of separate mention is the chapter on the surgical pathology of the thorax in which a section has been added about the pathology and pathologic physiology of congenital heart disease in recognition of the great surgical advances in this field.

The text is written along more or less conventional lines, and for practical purposes may be divided into two parts. The first part deals with a discussion of pathology in general and the second with the pathology of the various organs and portions of the body. The common conditions are discussed in more detail than those which are not so common. Most of the material is presented in a concise form and written in excellent style. In some places the author is to be commended for being very instructive and conservative. For example, in describing Papanicolaou's method of diagnosing uterine cancer by examining the cells of a vaginal smear, he states: "The material is aspirated, blown onto a slide, fixed before allowing to dry and stained." These instructions are very important as any pathologist will state who has received a dried, unfixed and unstained smear on a slide with a request to examine it for malignant cells. In the same paragraph, still speaking of this diagnostic method, he continues: "A positive result indicates that a confirmatory biopsy should be performed." In other places he makes unusual statements such as: "A very remarkable and interesting form of sarcoma of the endometrium is the grape-like sarcoma of the cervix." When discussing hypernephroma and hypernephroid tumors, especially of the kidney and ovary, he seems to use the terms interchangeably when by definition they have distinctly different meanings. Also his ideas about these two tumors do not agree with those of many authors in this country.

Dr. Boyd has continued to include a summary of the clinical symptoms so that the relation of the pathology to the symptomatology may be demonstrated. This is extremely important in establishing a scientific basis for the interpretation of clinical findings.

The bibliography though not extensive is adequate and, of even more importance, wherever possible the references used are in the English language.

In spite of a few differences of opinion it is my feeling that this is one of the better books on this subject.

A. Ralph Monaco, M.D.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

The Years after Fifty. Wingate M. Johnson, M.D., Professor of Clinical Medicine and Chief of Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College, with a Foreword by Morris Fishbein, M.D., Editor, *Journal of the American Medical Association.* Price, $2.00. Pp. 147. New York: McGraw-Hill, 1947.

The Internal Fixation of Fractures. Charles Scott Venable, M.D., F.A.C.S., Diplomate, American Board of Surgery; member, Fracture Committee of the American College of Surgeons, American Academy of Orthopedic Surgeons, Southern Surgical Association, American Association for the Surgery of Trauma, and Texas Surgical Society, and Walter Goodloe Stuck, M.D., M.S. (Orth. Surg.), F.A.C.S., Diplomate, American Board of Orthopedic Surgery; member, Fracture Committee of American Academy of Orthopedic Surgeons, Southern Surgical Association, American Orthopedic Association, American Association for the Surgery of Trauma, and Texas Surgical Society, with a Foreword by Ralph K. Ghormley, M.D., F.A.C.S., Professor, Orthopedic Surgery, Mayo Foundation; Consultant, Orthopedic Surgery, Mayo Clinic; Consultant, Orthopedic Surgery, Veterans Administration. Price, $5.50. Pp. 241, with 84 figures. Springfield, Ill.: Thomas, 1947.

Acknowledgment is also made of the following books:

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1946, with the comments that have appeared in the *Journal.* Chicago: American Medical Association, 1947.

New and Nonofficial Remedies—1947, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1947. Issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Philadelphia: Lippincott, 1947.

The Pharmacopoeia of the United States of America, 13th rev., by authority of the United States Pharmacopoeial Convention. Prepared by the Committee of Revision and published by the Board of Trustees. Official from April 1, 1947. Pp. 957. Easton, Pa.: Mack Publishing Co., 1947.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgment is made:

"Trends in Dentist-Population Ratios." Joseph W. Mountin, Elliott H. Pennell, and Georgie S. Brockett. Public Health Reports, November 22, 1946.

"The Health Center: Adaptation of Physical Plants to Service Concepts." Joseph W. Mountin and August Hoenack. Public Health Reports, September 20, 1946.

"A Survey of Facilities for the Care and Treatment of Alcoholism in New York City." The Committee on Public Health Relations of The New York Academy of Medicine. Quarterly Journal of Studies on Alcohol, December 1946.

"Health Conditions in Certain Large Cities of the Far East after Liberation." Henry R. O'Brien. Public Health Reports, September 13, 1946.

"Tularemic Pneumonia: Treatment with Streptomycin." R. L. Peterson and R. R. Parker. Public Health Reports, August 23, 1946.

"Current Trends in Medical Care." Willard C. Rappleye, New York Medicine, August 5, 1946.

"The Industrial 'Control Chart' Applied to the Study of Epidemics." Willis H. Rich and M. C. Terry. Public Health Reports, October 18, 1946.

"Typical Structures on Replicas of Apparently Intact Tooth Surfaces." David B. Scott and Ralph W. G. Wyckoff. Public Health Reports, September 27, 1946.

"The Nature of the Soluble Antigen from Typhus Rickettsiae." Charles C. Shepard and Ralph W. G. Wyckoff. Public Health Reports, May 31, 1946.

"Gonioscopy." Ernest A. W. Sheppard and Walter J. Romejko. American Journal of Ophthalmology, February 1947.

"The Treatment of Toxic Thyroid Disease with Thiouracil." E. M. Watson. Edinburgh Medical Journal, 1946, 53, 609.

"An Evaluation of Three Plague Vaccines against Infection in Guinea Pigs Induced by Natural and Artificial Methods." N. E. Wayson, Margaret C. McMahon, and Frank M. Prince. Public Health Reports, October 18, 1946.

"Intrathecal Administration of Penicillin in General Paresis." George D. Weickhardt. American Journal of Syphilis, Gonorrhea, and Venereal Diseases, May 1946.

"Does Milk between Meals Hamper the Appetite or Food Intake of the Child?" Irving J. Wolman. The Journal of Pediatrics, June 1946.

"Gastric Phase of Milk Digestion in Childhood." Irving J. Wolman. American Journal of Diseases of Children, April 1946.

CHARLES EMORY FERGUSON, M.D.
(1873–1947)

Dr. Charles E. Ferguson, a Life member of the District Medical Society, died August 14, 1947, at his home, 1414 Delafield Place, N.W., after an illness extending over four years. For almost fifty years, 1896 to 1945, he had practiced medicine in the District of Columbia.

Dr. Ferguson, born December 27, 1873, was a native of Rockville, Indiana, the son of George R. and Emma Bliss Ferguson. He received his early education at Alton, Illinois. After his family moved to the District in 1889, he attended schools in Washington, graduating in medicine from the old National University (now George Washington University) in 1896. He interned at Columbia and Sibley Hospitals. During World War I he served as Lieutenant in the Medical Corps of the Army.

In 1888 Dr. Ferguson became a member of the Medical Association of the District of Columbia and the following year he was elected to membership in the Medical Society of the District of Columbia. He became a Life member on January 1, 1939. He was also a Fellow of the American Medical Association.

His only survivor is his wife, Mrs. Adah Wilhite Ferguson.

CHARLES AURELIUS SCHUTZ, M.D.
(1893–1947)

Dr. Charles A. Schutz, pediatrician, who resided at 7002 Arlington Road, Bethesda, Md., died August 17, 1947, at Doctors Hospital, following a brief illness.

Dr. Schutz was born in Frostburg, Maryland, June 9, 1893. After graduating from high school he was employed at the Bureau of Standards. He served overseas during World War I in the ordnance department as an officer. Upon returning from service he enrolled at George Washington University for premedical study. In 1926 he received his degree in medicine from Washington University Medical School in St. Louis. The following two years he spent as an intern in hospitals in St. Louis. Upon returning to Washington to engage in private practice, he was appointed to the staff of Children's Hospital. At the time of his death he was a senior staff member at Children's and secretary of the medical staff. He was also attending physician at Suburban Hospital.

Dr. Schutz served on the faculty of George Washington University School of Medicine as Clinical Professor of Pediatrics and as Associate in Pediatrics at the University Hospital.

He was elected to Active membership in the District Medical Society in 1929. After moving his office to 4648 East-West Highway, Bethesda, early in 1946, he transferred his membership to Associate. He was a member of the American Medical Association.

Surviving are his wife, Mrs. Helen Schutz; two stepchildren, Ann and Jane Swanger; and a sister, Mrs. Virginia Kerr, of Frostburg, Md.

WILLIAM CHARLES WHITE, M.D.
(1874–1947)

Dr. William Charles White, internationally known physician and for many years a resident of Washington, died August 10 at the home of his daughter, Mrs. Hugh Taylor Nicolson, in Westmoreland Hills, Md., after an illness of several weeks. Dr. White resided at 1914 Connecticut Avenue, N.W.

Born in Woodstock, Ontario, September 3, 1874, Dr. White received the degrees of M. B. (1898) and M. D. (1902) from the University of Toronto. He began his long public career as Professor of Pathology of Central College of Physicians and Surgeons at Indianapolis, 1900–05. The following two years he was Professor of Neuro-anatomy and Clinical Psychiatry at Indiana University, and from 1908 to 1916 he held the position of Associate Professor of Medicine at the University of Pittsburgh.

During World War I he served in France and Italy as director of the American Red Cross Division for relief and prevention of tuberculosis. Since 1923 he had been engaged in research at the National Institute of Health, having been called to Washington in 1921 by the Secretary of the Treasury to act as chairman of the Consultants on Hospitalization for veterans.

From 1907 to 1923 Dr. White was a director of the Mellon Research Laboratory, and from 1920 to 1946, Chairman of the Committee on Medical Research of the National Tuberculosis Association. For three years, 1933–36, he was President of the D. C. Association for Prevention of Tuberculosis. He was also a director of the District of Columbia Cancer Society, the Washington Home for Foundlings, and the Warwick Memorial Clinic. He was chairman of the District Health Officer's Advisory Committee on Drug Addiction.

Among the many scientific organizations of which Dr. White was a member were the American Association for the Advancement of Science, the Association of American Physicians, American Climatological Association, the New York Academy of Medicine, and the Tuberculosis Society of Scotland (honorary). He was a charter member of the Washington Academy of Medicine and a Past President of the Cosmos Club.

Two daughters survive, Mrs. Nicolson, and Mrs. William Cantrell Goodwyn, of Louisville, Ky., together with a brother and four sisters, who reside in Canada.

Malaria—Wilner

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7. Committee Bulletin: Proc. Staff Meet., Mayo Clin., 1946, **21**, 269.
8. Carney, S. P., and Levin, N. B.: J. A. M. A., 1944, **124**, 1048.
9. Dulaney, A. D., Stratman-Thomas, W. K., and Warr, O. S.: J. Infect. Dis., 1942, **70**, 221.
10. Loeb, R. F.: J. A. M. A., 1946, **132**, 321.
11. Most, H., and others: Ibid., 1946, **131**, 963.
12. Correspondence: Ibid., 1946, **132**, 104.

Ophthalmic Surgery in World War II—Greear

(*Continued from page 477*)

BIBLIOGRAPHY

1. Spaeth, E. B.: J. Ophth., 1937, **20**, 897.
2. Scarpa, A.: A Treatise on the Principal Diseases of the Eyes, 2nd ed. London: T. Caddell & W. Davies, 1818, p. 183.
3. Wiener, M.: J. A. M. A., 1909, **53**, 762.
4. Hilgartner, H. L., and Hilgartner, H. L., Jr.: South. M. J., 1931, **24**, 574.
5. James, W. M.: Tr. Am. Ophth. Soc., 1941, **39**, 438.
6. Castroviejo, R.: Ibid., 1943, **41**, 222.
7. Spaeth, E. B.: The Principles and Practice of Ophthalmic Surgery. Philadelphia: Lea, 1939, p. 207.
8. De Voe, A. G.: Am. J. Ophth., 1945, **28**, 1346.
9. Pfeiffer, R. L.: Arch. Ophth., 1943, **30**, 718.
10. Cutler, N. L.: Am. J. Ophth., 1946, **29**, 176.
11. Spaeth, E. B.: See ref. 7, p. 210.
12. Berens, C., Editor: The Eye and Its Diseases. Philadelphia: Saunders, 1936, p. 1079.
13. Wheeler, J. M.: Ohio M. J., 1921, **15**, 455.

Radical Pancreaticoduodenectomy—Putzki and Scully

(*Continued from page 491*)

14. Whipple, A. O.: (a) Ann. Surg., 1945, **121**, 847; (b) New England J. Med., 1942, **226**, 515.
15. Saltzstein, H. C., and Rao, J.: Arch. Surg., 1946, **53**, 434.

16. Strode, J. E.: Surgery, 1945, **18**, 115.
17. Trimble, I. R., Parsons, J. W., and Sherman, C. P.: Surg., Gynec. & Obst., 1941, **73**, 711.
18. Whipple, A. O., Parsons, W. B., and Mullins, C. R.: Ann. Surg., 1935, **102**, 763.
19. Cole, W. H. (Chicago), and Reynolds, J. T.: Surgery, 1945, **18**, 133.
20. Cattell, Richard B.: S. Clin. North America, 1943, **23**, 753.
21. Poth, E. J.: Surgery, 1944, **15**, 693.
22. Miller, J. M., and Wiper, T. B.: Ann. Surg., 1944, **120**, 852.
23. Dragstedt, L. R., Clark, D. E., and Vermeulen, C.: Ibid., 1939, **110**, 907.
24. Dragstedt, L. R.: J. A. M. A., 1940, **114**, 29.
25. Mullen, B. P.: Northwest Med., 1945, **44**, 14.
26. Blalock, A.: New England J. Med., 1944, **231**, 261, 293; correction, 1944, **231**, 559.

Editors' Forum—Vest

(*Continued from page 518*)

inadequate, and failure rather than success will attend his efforts. If we as individuals observe our obligations and fulfill our civic and professional duties, our personal public relations will take care of themselves and all things else in the realm of public relations of the profession will be added unto us.

Washington Physicians of Yesterday—Adams

(*Continued from page 523*)

be a special forte of his. He was a vigorous and influential crusader for the health, hygiene, and sanitation of Washington, being an active member of many important committees devoted to those objects. He was also a member of the Washington Obstetrical and Gynecological Society, and of the Congress and Association of American Physicians.

Dr. Adams had high literary and scientific attainments. At his baccalaureate graduation in 1875 he delivered what was regarded as a brilliant oration; and he was his class valedictorian in 1879. He was a prolific contributor to medical literature; and he delivered numerous addresses and lectures to medical schools and societies in various parts of the country. His publications numbered nearly a hundred titles.

He was of cheerful and friendly disposition, benevolent, congenial, dapper in appearance and manner, scholarly and keen, a familiar figure in the proceedings of the Medical Society. He exemplified the best ideals of the medical profession.

On December 6, 1923, Dr. Adams was given a dinner by his colleagues, with presentation of a silver pitcher, in celebration of his seventieth birthday.

Dr. Adams continued in active and energetic practice to the very end of his life, and died suddenly and unexpectedly on February 12, 1928, having been taken ill on the day previous while attending a patient.

He married Lida W. Hollister, April 30, 1890. A son, Dr. Frank Dennette Adams, is now an able internist in Boston.

John B. Nichols, M.D.

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SOME CLINICAL OBSERVATIONS ON THE USE OF CURARE IN ANESTHESIA

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ALTHOUGH Sir Walter Raleigh in his account in 1595 refers to curare and its war use, it was not until 1942 that Dr. H. R. Griffith[1] of Montreal used the extract of curare at the suggestion of Dr. L. A. Wright of New York as an adjunct to anesthesia in the human. Following this report there was so much favorable comment by others who used this agent that its place in anesthesia was definitely established. Clinically the range of usefulness of curare is still expanding and its possibilities have not as yet been fully realized.

In this paper we are discussing the alkaloids of the crude drug curare. They are intocostrin (extract of purified curare, Squibb) and d-tubocurarine chloride. The formula of the latter is $C_{38}H_{41}O_6N_2Cl_2$ and has a molecular weight of 695. In addition it forms a pentahydrate which has a molecular weight of 785 ($5H_2O$). The "d" in d-tubocurarine chloride means that it is dextrorotatory. We have been using both of these alkaloids of curare, but for clarity in this paper we shall use the term curare except in specific instances.

It may be well stated that it was no easy problem to provide the medical profession with intocostrin and d-tubocurarine chloride. The research chemists deserve a great deal of credit for isolating the active alkaloidal extracts of curare and making it available to all. Also, Cullen[2] states, "The biological assay for this drug is, fortunately, one of the most reliable and consistent methods of assay available."

The action of curare is probably at the myoneural junction but the exact method of its action at this site is not known. According to Gross and Cullen,[3] it seems that curare affects peripheral action by interference with the ability of the muscle cell to respond to the nicotine action of acetylcholine. Steiman[4] states that "block by curare is due to the fact that the drug raises the threshold of muscle to acetylcholine." As to the fate of curare in the body, it is believed that most of the drug is excreted, some of the drug is probably metabolized. It is not probable that curare is pooled at the myoneural junction. There is now the fairly general conception that curare is capable of acting anywhere in the nervous or muscular system where acetylcholine is the activating agent. Luco and Mesa[5] have concluded from experimental work on cats that curare can partially block the transmission between parasympathetic (cholinergic) postganglionic fibers and the effector but does not block the transmission between the sympathetic postganglionic (adrenergic) fiber and the effector. Since curare does not interfere with the liberation of acetylcholine (Dale, Feldberg and Vogt, 1936) nor with the mechanism which elicits the effector response, it is concluded that the effect of the drug is to prevent the acetylcholine, normally liberated, from producing a stimulus. It has been shown by Mautner and Luisada[6] that in cats and dogs the vagus nerve can be paralyzed by curare, and peculiarly enough this paralysis can be overcome by asphyxia. Clinically the actions of curare are primarily peripheral and have little or no central action.

Curare has been used as an anesthetic adjunct at the Garfield Memorial Hospital since early in 1945. In over 1,000 administrations of this drug we have been impressed with its actions and have gradually expanded our usage of this agent. We feel that the drug is indicated in many more procedures and anesthetic complications than is generally realized.

It cannot be too greatly stressed that one must have a patent airway when curare is being used. This is imperative because if respiratory exchange is inadequate, manual insufflations can be instituted until such time as the patient can resume a normal exchange. Depressed respirations with curare usually cause a slight rise in blood pressure; this may be explained by the carbon dioxide blood excess resulting from inadequate gaseous exchange. Supplemental insufflations are indicated should apnea, diminished exchange, or significant blood pressure rise result from curare administration. We have seldom used the physiologic antagonists of curare but believe they are of definite value, particularly if surgery is completed before the curare effect has worn off. No temporary or permanent parenchymatous body changes have been demonstrated as due to curare per se, but asphyxial anoxic changes must be guarded against by an adequate respiratory exchange at all times. Intravenous administration is preferable, since its action is more easily controlled. Maximal effects occur in 2 to 8 minutes and its action lasts from about 20 to 35 minutes. Subsequent intravenous dosage may have cumulative and prolonged effects and should be given with caution. It should also be remembered that smaller amounts of curare should be given when ether, sodium pentothal, and tribromethanol are used, since these agents also have a curariform action.

Since 1933 more than 12,000 cyclopropane anesthetics have been given by the anesthetic staff of the Garfield Memorial Hospital and it is only natural that most of our work with curare has been with patients under cyclopropane anesthesia. The two drugs seem to make an ideal combination, and excellent relaxation may be attained with minimal amounts of each agent. Physiologically these agents are apparently well suited. Cullen[7] states, "Clinical experience leads us to believe that curare does not potentiate the cardiac irregularities produced by cyclopropane and may afford some protection. If cardiac irregularities during cyclopropane anesthesia are produced by stimulation of a center in the brain stem and transmitted through sympathetic fibers, or if they are due to vagal escape phenomena, it is a theoretical possibility that blocking of response to acetylcholine by curare would be beneficial." A light plane of cyclopropane anesthesia can be maintained with curare supplement, and relaxation is rapid without the difficulty, delay, or the complications of ether or spinal block technics. We do not think, however, that curare should be made the excuse for a poor anesthetic improperly given.

With the increasing use of the electrosurgical unit for all types of surgical procedure, it is imperative to use nonexplosive gas mixtures.

We have been using nitrous oxide-oxygen-curare, avertin-nitrous oxide-oxygen-curare, sodium pentothal-curare and sodium pentothal-curare-nitrous oxide-oxygen combinations for various surgical procedures when these electric machines are used. Respiratory depression with these combinations is not significant if the curare is carefully administered. We think that curare may be contraindicated in patients having severe anemia, in chest operations, and with patients in the prone position. Anesthesia with endotracheal intubation for operations about the head and neck is particularly facilitated with the use of curare. In all instances an endotracheal catheter should be used for surgical procedures in this region. Not only does curare relax the muscles of the neck and throat making intubation easier, but, with a proper nonexplosive supplement, provides an excellent anesthetic combination that obviates any explosion hazard.

Curare seems particularly indicated in the poor risk and in the aged patient. Light cyclopropane anesthesia, with curare for relaxation, in our opinion is usually the anesthetic of choice for these groups. There are less physiologic body changes with curare, a minimal degree of respiratory depression, and yet excellent relaxation. The patient reacts rapidly and has no prolonged postoperative period of depression. Many patients are awake and talking before leaving the operating room. Postoperative pulmonary complications are greatly obviated, since many of the factors which predispose to pulmonary complications are eliminated. Adams[8] states, "It would appear logical that use of an agent (curare) whose effects resulted largely from peripheral action might not produce as many untoward effects as large doses of an agent whose predominant effect was depression of the central nervous system. Actually the truth of this statement seems to be increasingly apparent as time goes on." The following case reports are briefly cited; these poor-risk or aged patients were administered a curare combination for their surgical procedure.

A 60-year-old colored male with carcinoma of the head of the pancreas was extremely emaciated, deeply jaundiced, and suffered from a severe anemia. He had spinal cord changes which were probably precipitated by his low blood count. After preliminary supportive therapy including multiple transfusions, this patient was anesthetized with avertin (60 mg. per kilo.), nitrous oxide-oxygen-curare endotracheal technic for 5 hours and 20 minutes for a cholecystoduodenostomy and various other intestinal anastomoses. During the entire operative procedure an electrosurgical unit was freely used. The blood pressure varied from 90/60 mm. Hg to 110/70 mm. Hg; the pulse rate varied from 80 to 90 per minute, and the respirations from 16 to 20 per minute. Two hundred forty units of d-tubocurarine chloride was administered during the course of this abdominal procedure along with nitrous oxide-oxygen (65–35 per cent). The respiratory exchange was always adequate and the relaxation excellent. Upon completion of the operation the patient immediately awoke and stated that he felt fine but was a little tired.

A 63-year-old white male was admitted with severely painful recurrent episodes of cholelithiasis. These attacks were so disturbing to the patient that he demanded that his gall bladder be removed even though he was warned by the surgeon that he was an extremely poor surgical and anesthetic risk. He had had 3 known attacks of coronary artery occlusion, hypertensive heart disease, cardiac dilatation, and 2 bouts of cardiac decompensation. In addition, he also had extreme liver enlargement, cholelithiasis, and cholecystitis. For the past several years he had been treated for moderately severe diabetes mellitus and chronic nephritis. His weight loss had been 70 pounds in the 6 months prior to admission. The patient wanted relief from his pain regardless of his various pathologic conditions or his chances of surviving the surgical procedure. After preliminary medication with pantopon, gr. 1/3, and scopolamine, gr. 1/150, the patient was induced with cyclopropane-oxygen sequence, then 40 units of intocostrin was given intravenously just prior to opening the peritoneal cavity. The same dose was again given just prior to closure of the peritoneum. The patient's anesthetic course was benign, and the abdominal relaxation was excellent. The patient reacted before he left the operating room and subsequently made an uneventful recovery.

Although it is generally accepted that curare does not affect smooth muscle, clinically curare often seems to act as a smooth muscle relaxant as well as a relaxant of striated muscle. Several investigators have reported that curare apparently blocks vagal impulses and that it is entirely possible that it may have an action similar to that of atropine or scopolamine in relaxing smooth muscle. This action of curare makes it of extreme value for the treatment of laryngeal spasm. Knight[9] states, "Curare becomes the cure for one of the greatest nuisances, and even dangers, in anesthesia. Laryngeal spasm has always been one of the greatest banes of the anesthetist. I believe the time will come when no anesthesia will be started without curare at hand, even if it's for this purpose alone." One can under direct vision observe the relaxation of the neck muscles, pharyngeal muscles, and muscles of the larynx, and then see the relaxation of the vocal cords themselves as curare is being given. In 10 cases of mild to severe laryngeal spasm 40 to 100 units of curare given intravenously has relieved 9 cases in the average time of 92 seconds. The tenth case probably had inadequate dosage for relaxation. Bronchial spasm may occur from the administration of curare. This, however, is very infrequent, and according to Whitacre and Fisher[10] is due to inadequate general anesthesia and an insufficient amount of curare to cause skeletal muscle paralysis. The treatment of bronchial spasm consists of immediate tracheal intubation, if the patient has not been intubated, and oxygen insufflations under pressure. Additional curare may relax the bronchial spasm if insufflations are determined to be too difficult.

We have never had a laryngeal spasm occur in a patient after curare has been administered. This in itself is significant, since upper abdominal surgery often precipitates laryngeal spasm under gas—oxygen or gas—oxygen-ether anesthesia in the patient that has not been intubated. In our series with curare supplement in these same procedures spasm has not occurred. The following case illustrates the value of curare in overcoming laryngeal spasm.

A 42-year-old, muscular, colored male was given nitrous oxide-oxygen-ether sequence for an oral procedure. It was not previously known that the patient had had lunch before this afternoon operation. During induction the patient vomited, partially aspirated stomach contents, and developed a profound laryngeal spasm. It was impossible to open the mouth, and suction of the vomitus was only fairly accomplished by nasopharyngeal catheter. Oxygen could not be forced past the spastic cords. Curare (100 units) was immediately given intravenously. In 72 seconds the jaws relaxed, the pharynx was suctioned, an oral, cuffed endotracheal tube was easily passed through the relaxed vocal cords, and the tracheal cuff was inflated with 7 c.c. of air. After brief but adequate tracheal suction, positive pressure oxygen insufflations were started. The patient almost immediately regained his normal color and spontaneous respirations ensued three minutes after insufflations were begun, the patient reacted promptly and was none the worse for his experience.

The use of curare in obstetrics has been extremely interesting. According to Harroun, Beckert and Fisher[11] in their work on dogs, curare does not pass the placental barriers or paralyze uterine musculature. From the unpublished works of Squibb and Sons[12] we have the information that blood levels for curare estimation can now be done but not on sufficiently small concentration, as yet, to be clinically significant. It is believed that there is enough curare in the mother's circulation to affect the baby should it pass the barriers.

From unpublished reports of our colleague, Dr. S. Katzman,[13] curare seems to have possible indications in obstetrics. He usually induces the patient with ethylene-oxygen anesthesia, then gives 40 to 60 units of curare intravenously 2 to 5 minutes before delivery is started. This procedure usually produces mild to marked perineal relaxation. Only small mid-line episiotomies are necessary in most cases. There have been no apparent curare effects on the babies. They require the same resuscitative care such as suction and oxygen insufflations as with any other type of obstetrical management. Postpartum bleeding has been no more marked with curare than without it. In 2 cases curare was administered to patients for the delivery of an unsuspected twin when ergotrate had been given after the birth of the first baby. In each case the contractions of the uterus and lower abdominal muscles eased, allowing safe delivery of the second child. Each baby cried and was active in a normal period of time.

Our personal obstetrical experience with curare has been limited to its use in only 13 cases. Several obstetricians have said that the forceps pull necessary for delivery is appreciably less with curare. In 2 of the 13 cases a phenomenon of apparently no clinical significance occurred. This consisted of active rotation of the fetal head from the mid-line to one side and back to mid-line with one respiration, then to the opposite side and back to mid-line with the next respiration. This alternating restitution described an arc of about 120 to 150 degrees and occurred while the fetal head was within the vagina and when the head had been delivered. This may probably be explained by marked muscle relaxation of the pelvic floor.

Other investigators have claimed that versions, extractions, high forceps deliveries, and retained placentas have been well handled under gas-oxygen-curare anesthesia. It is probably too soon to evaluate the clinical results with curare in obstetrics. It is also possible that the short duration of time between the giving of curare to the mother and the delivery of the baby may explain the non-curare effect upon these babies.

Shock is enhanced by anesthetic agents. It has been long known that deep planes of surgical anesthesia for a short period of time may be more shocking to a patient than light anesthesia for a prolonged period of time. It is true that patients in shock do not require as much anesthesia for relaxation as do normal patients. If muscular relaxation is needed, however, in the shocked patient, curare seems to be the safest agent for the production of relaxation in these instances. Therefore, we feel that light general anesthesia with supplementary curare for relaxation is one of the safest ways of handling the shocked patient. This technic was used in the following case report.

A 32-year-old colored male was admitted in shock. He had been shot through the abdomen at close range, and although he was operated on 3 hours after the shooting, the intestine was markedly distended. After receiving plasma and being cross-matched for blood, surgery was started. Anesthesia consisted of induction with pentothal, 0.4 Gm., and curare, 60 units. The patient was intubated orally, and the tracheal cuff was inflated with 7½ c.c. of air. The blood pressure was initially 70/50 mm.Hg, and the pulse rate 120 per minute. The respirations were 24 per minute. Cyclopropane-oxygen supplement was used after the tracheal tube was placed. Minimal subsequent doses of curare were given to maintain adequate relaxation while the surgeon sutured a lacerated liver, explored the entire gastrointestinal tract. and closed a perforated jejunum. This patient developed hiccoughs when extreme traction was made on the liver. After 24 minutes an additional dose of curare was given (40 units), and the hiccoughs disappeared. At the end of the surgical procedure the patient's blood pressure was 110/75 mm.Hg, and the pulse rate was 106 per minute. The patient reacted in 10 minutes and seemed to be none the worse for his surgical and anesthetic venture. The total curare dosage was 110 units.

We have used curare in 3 cases of tetanus. We think it definitely superior to avertin and the barbiturates in controlling the muscle spasms and pain in these patients. The drug does not alter the course of the disease. Curare provides muscular control without central depression of the tetanus patient. The muscles of the head and neck relax, the jaw sags, the extreme opisthotonos disappears, the respirations become less labored, and the appearance of apprehension eases. The dosage is almost an individual problem, but a dose about every 4 to 6 hours seemed to suffice in the cases treated.

We have recently used curare in orthopedic procedures in which good muscular relaxation was needed. In open reductions the muscle pull on the overriding fragments was remarkably overcome by the intravenous injections of curare. Actually, in several cases overcorrection could be made after curare therapy, whereas approximation could not be attained before.

Summary and Conclusions

Curare is a very valuable aid to the anesthetist. It need no longer be said that curare is only used to correct a poorly given anesthetic. It has many indications and uses in its own right.

In over 1,000 administrations of this agent we feel that its usage is by no means fully explored.

We have found that curare-cyclopropane anesthesia is many times the anesthetic of choice, particularly in the poor-risk, aged, or shocked patient. The fact that a patient may be kept in the first plane of surgical anesthesia and still have excellent muscular relaxation with curare administration minimizes the anesthetic hazard of this group of patients. Curare does not cause inherent parenchymatous body changes, interference with gas hemoglobin exchange, alter the output of the glands of internal secretion, or cause variable changes of the acid-base mechanism as do general anesthetic agents that depress the activity of the central nervous system.

Curare is the most effective drug at our disposal in relieving laryngeal spasm, since curare seems to relax smooth muscle as well as striated muscle. It also greatly facilitates endotracheal intubation. In 9 of 10 cases mild to severe laryngeal spasms were relieved in the average time of 92 seconds. Laryngeal spasms did not occur in patients after curare administration had been given.

Since the explosive range of ether-oxygen and nitrous oxide-oxygen-ether mixtures in a closed system is greater than any other combination followed in order by ethylene, then cyclopropane-oxygen mixtures, it is important to exert due caution in administering these agents. Curare with nitrous oxide-oxygen, avertin-nitrous oxide-oxygen, pentothal sodium, and pentothal-nitrous oxide-oxygen not only provides a nonexplosive anesthetic combination but also provides adequate relaxation for almost all surgical procedures.

It is theoretically possible that curare by blocking the effects of the vagus and cholinergic fibers may well protect the heart from the action of such drugs as cyclopropane.

Experimentally and clinically curare does not pass the placental barriers. The babies are apparently not affected and there has been no abnormal postpartum bleeding.

Curare has been used favorably in tetanus and orthopedic procedures when muscle relaxation has been needed.

Curare has many clinical uses and undoubtedly will have more in the future.

BIBLIOGRAPHY

1. Griffith, H. R., and Johnson, G. E.: Anesthesiology, 1942, **3**, 418.
2. Cullen, S. C.: South. M. J., 1945, **38**, 144.
3. Gross, E. G., and Cullen, S. C.: J. Pharmacol. & Exper. Therap., 1943, **78**, 358.
4. Steiman, S. E.: Am. J. Physiol., 1943, **140**, 269.
5. Luco, J. V., and Mesa, J.: Ciencia, 1941, **2**, 298.
6. Mautner, H., and Luisada, A.: J. Pharmacol. & Exper. Therap., 1941, **72**, 386.
7. Cullen, S. C.: Anesthesiology, 1944, **5**, 166.
8. Adams, R. C.: S. Clin. North America, 1945, **25**, 735.
9. Knight, R. T.: Minnesota Med., 1944, **27**, 667.
10. Whitacre, R. J., and Fisher, A. J.: Anesthesiology, 1945, **6**, 124.
11. Harroun, P., Beckert, F. E., and Fisher, C. W.: Surg., Gynec. & Obst., 1947, **84**, 491.
12. Squibb, E. R., and Sons: Private communication, May 1947.
13. Katzman, S.: Personal communication, June 1947.

PSYCHIATRIC ASPECTS OF EPILEPSY*

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In ancient times it was customary for witnesses of a convulsive attack to spit upon the helpless epileptic in order to protect themselves against the evil spirits that possessed the victim. The history of epilepsy is replete with similar examples of brutality, superstition, and fear, some of which persist even to the present day. However, social enlightenment and medical advances, especially within the last 20 years, have greatly improved the lot of the epileptic and particularly significant is the increasing awareness of the psychologic forces that operate in this disease.

It is the consensus among students of epilepsy that emotional factors can precipitate an attack in susceptible patients but that psychologic forces per se cannot produce the disease. However, a few still cling to a belief in a psychogenic etiology. Freud felt that a convulsion symbolized a release of neurotic tension that could not be controlled by the usual psychic mechanism. Ferenczi stated that there is regression to an infantile omnipotence by means of a magic gesture, the fit. Reich regards the convulsion as an extragenital muscular orgasm. Clark interpreted the fit as a flight from reality and expressed the belief that a basic personality defect precedes and eventually manifests itself in the convulsive disorder. Considerable attention has been given this latter conception of epileptic causation, and a long and bitter polemic persists over the possible existence of a basic epileptic personality structure. The term "typical epileptic personality" is still used by some to denote a combination of traits which allegedly characterizes all epileptics. Those who hold this view describe the so-called typical epileptic as a moody, embittered, irritable introvert, full of self-pity, cruel, selfish, irresponsible and subject to explosive bursts of violent temper.

Although such a personality pattern is sometimes exhibited by epileptics, it is not representative of the noninstitutionalized patients, most of whom are congenial, stable individuals, good citizens and grateful patients. The so-called epileptic personality is frequently found in institutionalized patients and probably is described by physicians who have had little experience with the nonhospitalized group. Furthermore, some of these traits, when present in epileptic patients, are often consequences of the stigma and social ostracism associated with the disease. The patient may be seclusive because he fears a seizure in public; he may be embittered because he is denied employment or social opportunity. Resentment, distrust, irritability, asocial trends and other undesirable traits often resolve under proper medical and psychiatric treatment.

In addition to the relatively uncommon "epileptic personality" the practitioner may encounter several other psychiatric syndromes associated with the convulsive disorder:

1. Psychopathic traits with convulsions may be due to head injury. It is expected that this syndrome will be encountered more frequently now as the result of head injuries due to combat. It is characterized by paroxysmal seizures with antisocial behavior between the attacks, occurring in an individual who prior to his head injury was stable and well integrated. Cause and

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effect relationships are not clear, but it appears that the head injury caused both the psychopathic behavior and the convulsion, since either may occur alone as the result of cerebral trauma. Alcoholism is sometimes a superadded complication.

2. Hystero-epilepsy is a vague term that has various connotations. In general, it is an hysterical attack occurring in an epileptic and simulating a real clinical seizure. It should be remembered that a nonepileptic may suffer an hysterical seizure unconsciously mimicking a convulsion, or an epileptic may precipitate an attack by volitional hyperventilation. The typical hysterical seizure occurs in an epileptic who has a superimposed neurosis. These hysterical attacks are often difficult to distinguish from bona fide seizures and many authorities feel that every phenomenon that can occur in a real convulsion can occur in an hysterical attack. Some generalizations that are helpful in differential diagnosis are:

	Epileptic Attack	*Hysterical Convulsion*
Onset	Sudden	Gradual
Sex	More males	More females
Time	Any time	Never in sleep
Presence of others	Indiscriminate	Often in presence of others
Injuries	Frequent	Usually avoided
Tongue	Bitten	Not bitten
Cry	Expiratory at onset	Continuous
Face	Cyanotic	Flushed
Movements	Tonic and clonic	Often bizarre
Duration	2–3 minutes	Many minutes
Sphincter	Often relaxed	Controlled
Babinski test	Positive	Negative
Consciousness	Lost	Present or incompletely lost

Of particular diagnostic importance is the electroencephalogram which may establish not only the presence of a true convulsive disorder, but also the epileptogenic focus.

The recognition of an hysterical seizure is of practical significance especially in children, since it signalizes an immediate need for psychotherapeutic attention. The hysterical attacks are usually precipitated by emotional stress, by frustration, or by an attempt to gain an objective. Skilled and individualized management is necessary to prevent or stop these attacks, and the family must steer a narrow course between too casual an attitude and oversolicitude. A stereotyped approach in these cases is predoomed to failure. When practical, the epileptic child should be given a considerable degree of independence, e.g., the full responsibility of taking his medication. He should be assured of his parents' sympathy and love, but he should not be permitted to intimidate the household nor to practice the tyranny of invalidism.

3. Psychic equivalents or psychomotor seizures are a manifestation of epilepsy, varying greatly in pattern but characterized by a clouded mental state in which the patient appears conscious, carries out more or less complex acts in an automatic and confused fashion, and has complete amnesia for the seizure. It may last for minutes or hours, during which he may mumble incoherently, may undress in public, wander about, and may commit violent antisocial acts; for example, a patient recently admitted to St. Elizabeths Hospital beat her small child to death with the rung of a chair during such an epileptic seizure. Occasionally the attack consists of a sudden change in mood, aggressive and unreasonable behavior, inconsistent with the patient's usual disposition. These psychic seizures have the same clinical significance as a grand mal or petit mal attack and one seizure is usually like another. They may immediately follow a convulsion or petit mal seizure and may occur independently of them. During these episodes the patients are often very irritable and bellicose, should be kept under close surveillance, restrained as little as possible, and care taken not to cross them.

4. Psychosis with convulsive disorder is an official diagnostic category applied to epileptic patients who display hallucinations, delusions, preoccupation, impulsiveness, hyperreligiosity, and characteristics previously described as the

epileptic personality. Often there are also present déjà vu phenomena, blunting of the affect, and poverty of interests. Hospitalization is usually necessary for this group.

5. Epileptic deterioration represents an end stage of the epileptic process, the cause of which is unknown. Patients become more seclusive, preoccupied with hallucinations and fantasy, display confusion, disorientation, impairment of memory, and impoverishment of intellectual faculties. Hospitalization is necessary.

The psychiatric approach to the epileptic patient is one of the most important aspects of this many-faceted problem. Objectives of good therapy can be obtained only by treating the patient as a whole and by being cognizant of the multiple psychic and social forces that play upon him. Individualization is a therapeutic imperative and the goal is a well-regulated life with preservation of the self-esteem and a minimum of restriction.

Psychiatric treatment begins with a physical examination which should be complete and unhurried. Even if a reliable history of convulsions is obtainable no commitment, silent or spoken, should be made about the diagnosis until all of the diagnostic data, including an electroencephalogram, are assembled. Then the patient should be informed what all these tests mean. A child should be told as little as possible, and even with the adult patient the first blow should be mollified. This can be done in part by using a more euphemistic term for epilepsy, such as convulsive disorder, seizure, etc., and even after the patient has accepted his illness, the term "epilepsy" or "fit" should be avoided.

A more direct procedure may be taken with the family, who should be informed of the true situation although no positive prediction should be made about the future. The family must be instructed to protect the patient against injury or against avoidable psychic trauma but should be warned against overindulgence.

Of course, the greatest psychologic benefit is effected by controlling the seizures with medication, but the physician should also take positive steps to reassure the patient and dissipate any feelings of defeatism that so frequently plague the epileptic. He can be told that his disorder is common, that it is related to migraine, that it will not affect longevity, that many famous people suffered convulsive disorders, that potent drugs are available to combat his illness, that new therapeutic agents are being constantly sought for and found. He should be dissuaded from sitting idle awaiting the next seizure and encouraged to find useful employment. The burden of inactivity weighs particularly heavy on these patients, and one of the most effective antidotes against neurosis is constructive work. He should be cautioned against working with or near moving machinery or at any job which would jeopardize his or his fellow workers' safety. Regardless of the nature of the work many employers are prejudiced against the patient with a convulsive disorder, but they may be persuaded to employ a patient if the latter signs a waiver releasing the employer from legal responsibility connected with an injury due to a seizure.

Hobbies and recreational diversions should be encouraged, but swimming and hazardous sports must be prohibited. Bibliotherapy is a useful tool, and for the patient who must be confined at home some form of occupational therapy should be recommended.

Where practical the patient should be encouraged to participate in social organizations to help overcome his self-consciousness and feelings of inferiority. Many patients have developed an active interest in the Laymen's League Against Epilepsy (50 State Sreet, Boston, Mass.), an organization which distributes interesting bulletins to its members and promotes research in epilepsy.

A psychiatric crisis may arise when the question of marriage develops. That decision, of course, should be left to the patient, but he

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POLLEN COUNTS—THEIR PROPER PLACE IN HAY FEVER

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WITHIN recent years the study of pollen counts has become quite popular, particularly in the daily press, and the average hay fever sufferer is much concerned over "the count," eagerly scanning his morning paper for the pollen count before he reads the headlines. There is no doubt that the study of the airborne pollens has contributed a great deal to the field of allergy,[1,2,3] and there is still a great need for more uniform and more widespread pollen counts. However, the actual importance of these pollen counts to the individual hay fever patient needs to be more critically considered.

Let us briefly review the usual method of pollen counts. A tall building is selected in some part of the city, the selection of the building being governed by convenience or availability. The pollen-collecting apparatus is exposed to the air from the roof of the building. The gravity pollen-collecting apparatus has been standardized by the National Pollen Survey Committee of the American Academy of Allergy,[4] and this holds a glass slide coated with petrolatum, exposed to the air for 24 hours. The slide is examined under the microscope, and the number of pollen grains are counted per unit area. With standard collection methods these figures of number of grains per area of slide can be converted to the number of pollen grains per cubic yard of air.

Now let us consider some of the weaknesses of this method as applied to the individual patient. In the first place the count is a measure of the total 24-hour deposit of pollen, and shows no difference between 50 grains deposited gradually over 24 hours and 50 grains deposited all within 1 hour, a great difference as far as the patient's reactions are concerned. However, the main fault of the gravity pollen count is that it is merely an average of the amount of pollen in the air over the counting chamber, and this is often no measure of the individual patient's pollen load, which is really the important factor as far as the patient is concerned.

Durham[5] has made extensive studies on spot tests of various pollens, using a hand-operated volumetric dust counter. This method while accurate is too involved for routine use, but it is very useful for calibration purposes and for spot tests. These tests have shown some of the weaknesses of the gravity pollen counts. For example, he has shown on one occasion that the spot test pollen count near a patch of ragweed was 9,600,000 grains per cubic yard of air while at the same time the gravity pollen count at the nearby weather station was 60 pollen grains in 24 hours. This discrepancy can best be illustrated by the realization that a ragweed sufferer passing by this patch would have inhaled about 6,000 grains per breath, and one could not explain his acute flare-up on the basis of the gravity pollen count. These results have been duplicated many times and for many different pollens, and they often show that a patient passing by a vacant lot on the corner will often inhale more pollen grains in a minute than the total pollen count of a season as reported on the gravity pollen collector.

These facts are important to the patient and to his physician, for otherwise they will not be able to understand the variations of his symptoms totally unrelated to the pollen count. The main problem is the total allergic load of the

(*Continued on page 594*)

ACQUIRED SYPHILITIC OSTEOMYELITIS

Report of Case Treated with Penicillin and Review of Literature*†

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ACQUIRED syphilitic involvement of bone is a late inflammatory manifestation occurring in the secondary or tertiary stages of the disease.[1] Of interest in this type of syphilis is the fact that most cases of bone involvement are asymptomatic, or remain so until the condition has advanced to the point of great destruction and mechanical impairment of function. Routine roentgenographic studies of all cases of late syphilis would most likely reveal many cases that are overlooked because of its asymptomatic character.[2] In congenital syphilis involvement of the bones is one of the characteristic manifestations. The lesions usually become manifested between 3 and 6 months of age by roentgenograms and then may disappear even with no treatment or with inadequate treatment.

The frequency of syphilitic involvement of the skeletal system has been recently studied by Buchman[2] and the conclusion made that it occurs in approximately 0.5 to 0.7 per cent of all cases of acquired syphilis. Buchman and Lieberman,[3] at the Hospital for Joint Diseases, in a study of 80,000 patients with orthopedic conditions from January 1, 1929 to December 31, 1938 found that there were only 119 cases with skeletal syphilis subjected to antisyphilitic therapy. Of the total number of cases with skeletal syphilis 25 were congenital and 94 acquired. Francis and Kampmeier[4] studied 67 cases of late acquired syphilis in which changes of the bones were noted on X-ray films. In 67 patients that were studied 117 bones were found to have X-ray evidence of disease. Many patients had multiple bone lesions. The tibial bone was most frequently involved. Next in order were clavicle, skull, fibula, femur, humerus, rib, ulna and scapula. Mohr, Scott et al[5] in a recent review of the literature come to the conclusion that if the entire skeletal system was examined roentgenologically in cases of late acquired syphilis it is probable that multiple lesions would be found to be even more frequent than indicated in the study by Francis and Kampmeier. Bailey[6] claims that syphilis of bone is seldom encountered in orthopedic practice at the present time and that when it does appear it is often not recognized. Wenger[7] in reviewing the literature comes to the conclusion that there is such great variation in reports on the incidence of syphilitic bone disease that it is practically impossible to reach definite conclusions as to whether there is a decrease or increase in this disease.

Stokes and co-authors[8] report on the use of pencillin in late syphilis and include in this group the treatment of syphilitic bone involvement. The cases were drawn from 8 clinics engaged in a study of the effect of pencillin on late syphilis under the auspices of the Committee on Medical Research of the Office of Scientific Research and Development. These authors have shown that in the cases with syphilitic lesions of the bones there was good response to treatment with penicillin in practically all cases.

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* The case herein reported was treated on the Medical Service at the Bronx Veterans Hospital, New York, where the author, while with the Army Medical Corps, was on the Internal Medical Service and Assistant to the Chief Cardiologist. Protocol was presented at the weekly medical conference, Dr. Russell L. Cecil, Medical Consultant, presiding.

† The plates were chosen by Dr. Archie Scheinmel, Chief of the Radiological Service, who also rendered the accompanying subtitles.

At the Bronx Veterans Hospital the case herewith reported was recently treated. Because of the rarity of syphilitic bone disease at this hospital, the extensiveness of the syphilitic involvement, interesting features in the diagnosis, and its response to treatment with penicillin, the case is reported in some detail.

REPORT OF CASE

I. J. C., a white male aged 50 years, was admitted on May 24, 1945, for the treatment of sciatic neuritis, right, severe. He was transferred to the medical ward with also another tentative diagnosis of possible malignant metastases to the bones. The patient served in the Navy in both World War I and World War II. In 1943, approximately 1 year after his entrance into the service in World War II, the patient developed a pain and formation of a "lump" in the left lower chest posteriorly. At that time he reported to the dispensary and received diathermy treatment to the painful area. Shortly after this several roentgenograms of the skeleton were made. According to the patient, the X-ray films showed findings in the ninth rib on the left side posteriorly and the tenth rib on the right side anteriorly. A lesion was also found in the right ischium. Another X-ray film of the right hip at this same time was normal. The diagnosis of these X-ray findings was not known by the patient. The patient was treated for a short interval by visits to the dispensary and was finally discharged for regular duty, apparently free of his symptoms. However, off and on for the past 2 years the patient had had pain in the right hip joint and right knee joint. While in the service these symptoms were never again severe enough to cause the patient to go on sick call. The patient was finally discharged from military service by reason of age, February 1, 1945. In March 1945 pain in the right hip and knee became severe and continuous. It was accompanied with some mild stiffness and a grating sensation on motion of the right hip joint. The patient's condition was progressively downhill and he could not leave his bed. There was severe pain in the right hip, right lower extremity, and the left side of the skull. The right knee and hip were kept in complete flexion both night and day. The patient gave a history of having weighed 160 lbs. on admission to the military service and at the time of the present admission weighed 119 lbs. The past history obtained from the patient was relatively negative. There had been no serious injuries or diseases. A cholecystectomy had been performed for cholelithiasis on April 25, 1942, and the patient had made an uneventful recovery. The patient had been married twice. He had been divorced from the first wife, who had later remarried and died of unknown cause. The second wife had died by reason of a cerebral hemorrhage, cause unknown. Patient denied having had any venereal disease.

The patient was emaciated and appeared chronically ill. Temperature, pulse and respiration were normal. His height was 70½ inches and his weight 119 lbs. There was tenderness to palpation over the left parietal area. The skin was pale and its turgor only fair. The pupils were round and equal, and reacted to light and accommodation. The head and neck were negative except that many teeth had been extracted. The blood pressure was 114/80. Examination of the heart revealed no abnormal findings. The lungs were apparently normal. The abdomen was normal except for an upper right rectus scar. The right hip and knee joints were kept in flexion. Motion of the right lower extremity was very painful, the patient complaining of pain in the right hip joint and whole thigh. Abduction of the right hip was accompanied by pain and a grating sensation, and the right lower extremity could not be extended even with force because of the severe pain. There was slight edema present in this extremity.

A hemogram revealed a mild secondary anemia. The white blood cell count was normal. The blood platelets were normal in number. Urinalysis was normal. Test for Bence-Jones protein was negative. Six blood tests showed Wassermann and Kahn 4 plus. Spinal fluid examination was normal. Blood calcium, inorganic phosphorus, cholesterol, and acid and alkaline phosphatase were all normal. A tuberculin test was 2 plus. Intravenous pyelograms were normal. Prostatic calculi were noted. Gastrointestinal X-ray examination was normal. The right pulmonary field revealed some productive infiltration at the outer one third. The heart and great vessels were normal. Roentgenograms of the bones throughout the body revealed alternating areas of radiolucence and bony sclerosis associated with numerous osteophytes. The dense sclerosis and osteophytes predominated in the ribs, a shoulder, a hip, and a tibia. The X-ray impression was syphilitic osteomyelitis. The bones involved were left parietal (fig. 1), ribs, left shoulder joint (fig. 2), the right hip joint, the right ischium (fig. 3), and right tibia.

A urologic examination was done, and the diagnosis rendered was urethral stricture and prostatic calculi. The patient was presented to the Staff Tumor Board, and a diagnosis was deferred. It was recommended that a biopsy of the right ilium in the region of the anterior superior spine be done. This biopsy was done on July 5, 1945. Histologic examination of the biopsy revealed findings compatible with syphilis or tuberculous involvement. The microsection (figs. 4 and 5) was verified by Dr. Fred Stewart of Memorial Hospital, consulting pathologist.

The biopsy ruled out malignancy. The roentgenologic findings were not typical of tuberculous bone involvement but were more characteristic of syphilitic bone disease. In view of these facts and the downhill course of the patient it was decided to institute a routine course of penicillin therapy for syphilis. On July 25, 1945 therapy was started which consisted of 40,000 units of penicillin intramuscularly every 3 hours for 60 doses, making a total of 2,400,000 units over a period of approximately 7½ days (July 25, 1945 to August 2, 1945). From then on the patient began to improve. The pains gradually disappeared. Palpation of the left side of head was not sensitive, and after a few weeks the patient was able to straighten out his right hip. Because of the extensiveness of the pathologic findings and fear of possible relapse, on September 27, 1945, which was 8 weeks after cessation of penicillin therapy, the patient was started on a series of mapharsen injections. These injections were 14 in number, given once per week, the last being given on December 19, 1945. This should in no way detract from the excellent results brought about by the penicillin therapy up to this time. From the time of institution of penicillin therapy, and before the injections of mapharsen, there was an 8-week interval during which the improvement was general and not limited to the bones alone. The patient gained 18 lbs. in weight, was able to move the involved joints, had no pain, and was physically stronger. On October 10, 1945, he had improved to the extent that he was walking with the aid of a cane. Following the penicillin therapy he was also put on potassium iodide, vitamins A and D, and calcium. The Wassermann and Kahn tests remained 4 plus.

Numerous series of roentgenograms of the bones were taken as the case progressed. The improvement shown radiologically was significant. There was no extension of the lesions either in size or number. The lesion in the left parietal bone showed a decrease in the osteolytic process and no extension of the pathologic lesion (fig. 6). There was increased sclerosis, disappearance of the periosteal reaction and some of the osteophytes, and better demarcation of the parts forming the left shoulder joint and right hip joint (figs. 7 and 8).

In obtaining the patient's history he was repeatedly queried as to ever having had a venereal disease, primary lesion, etc. He strongly denied any venereal disease. However, on November 10, 1945 his previous military service records were obtained and there was noted a "chancroidal" infection, May 19, 1919. On May 26, 1919, a Wassermann test had been performed, which was negative. No further serologic tests had been made or recorded. There were no serologic studies recorded during his last tour of active duty, January 26, 1942 to February 1, 1945. The X-ray diagnosis as recorded on the military service record stated that the lesions found in the ninth left and tenth right ribs were "old osteomyelitis, inactive."

Discussion

The variations of acquired syphilitic bone lesions are many and the condition may manifest itself as osteitis, periostitis, osteoperiostitis, osteomyelitis, gummatous formation, forms of arthritis and arthropathies.[1,2] To aid in classification Francis and Kampmeier,[4] leaving out congenital syphilis and arthropathies, used three groups: (1) periostitis, (2) gummatous osteitis, destructive osteitis or osteomyelitis, and (3) sclerosing osteitis.

The protean manifestations of syphilitic bone disease render the condition such that it may simulate tuberculosis of bone, osteogenic sarcoma, plasmacytoma, osteitis fibrosa cystica, metastatic bone lesions, pyogenic osteomyelitis, eosinophilic granuloma, and fungous infection. In this case the possibility of tuberculous or metastatic bone lesions was considered. Diagnosis in most cases should not be difficult if the condition is borne in mind and resort is made to an accurate history, serologic tests for syphilis, blood determinations for phosphatase, calcium, inorganic phosphorus, examination of the urine for Bence-Jones protein, and roentgenologic studies.

At times there may arise a case in which even after the above-mentioned steps have been taken there is still doubt as to whether or not the etiology is syphilis. It is possible to have bone involvement with negative serologic tests. Also, the patient could have syphilis with another coëxistent disease. In these cases a biopsy and microsection usually will make possible the diagnosis.

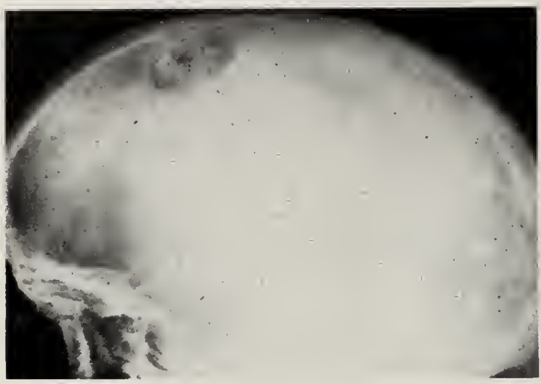

FIG. 1. Circular area of osteolysis with a serpiginous border indicative of gumma in the frontal parietal region.

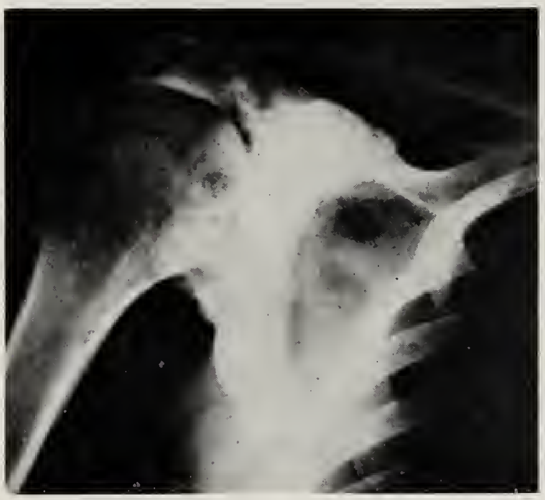

FIG. 2. Dense bone sclerosis interspersed with areas of osteolysis, periostitis along axillary border of scapula, and presence of some osteophytes.

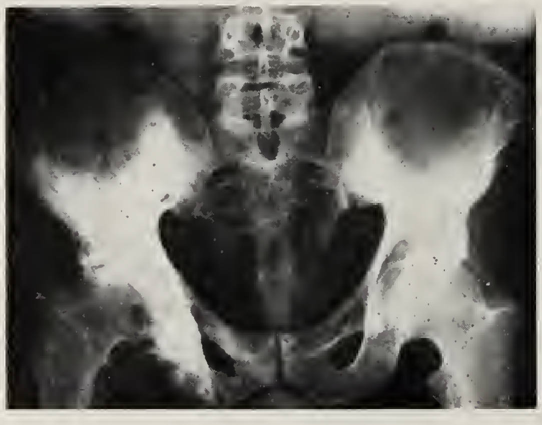

FIG. 3. Coarse osteophyte formation, dense bone sclerosis and areas of osteolysis.

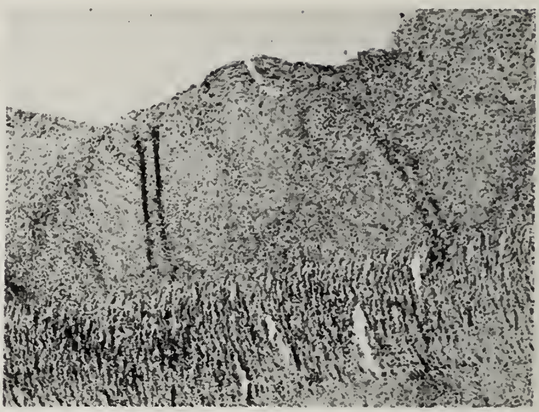

FIG. 4. Low power microsection of biopsy of ilium.

Easley[9] in his summary notes that the X-ray changes following treatment depend on whether the bony involvement is the proliferative type or destructive type. The proliferative type with new bone formations will show little or no changes. Lesions destructive in nature can show deposition of new bone in the diseased areas. Response to treatment in the adult with acquired syphilitic bone disease is slow, and the manifestations remain in the affected part as long as the individual lives.

With the increased enlightenment of the public as a whole, with better public health measures and improved chemotherapy, there is probably a great decrease in the incidence of syphilitic bone involvement. However, one can expect that with the turbulent conditions brought on by the War more cases of this disease

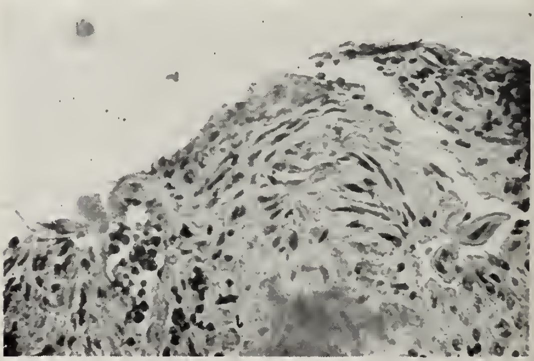

FIG. 5. High power microsection of section shown in figure 7. Numerous epithelioid cells, mononuclear cells and round cells are seen, with 1 giant cell in the field.

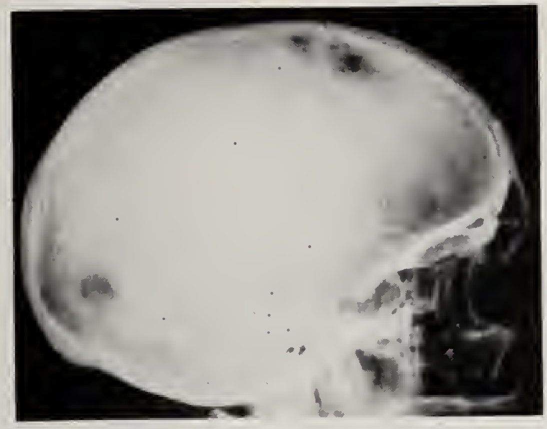

FIG. 6. Decrease in size of osteolytic area in skull (compare with fig. 1) after penicillin therapy.

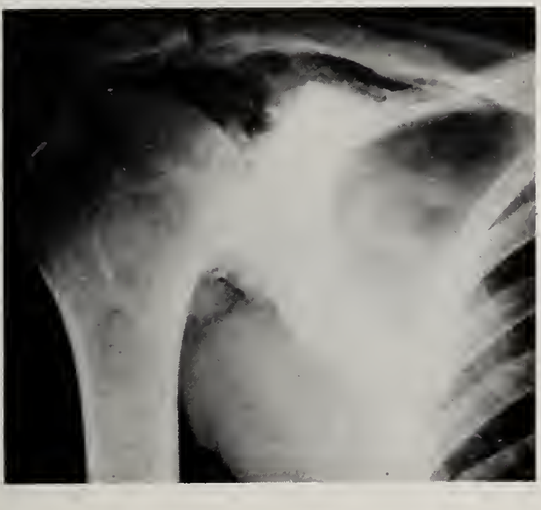

FIG. 7. Disappearance of the periostitis, decrease in osteolysis, and sharp demarcation of bone (compare with fig. 2) after penicillin therapy.

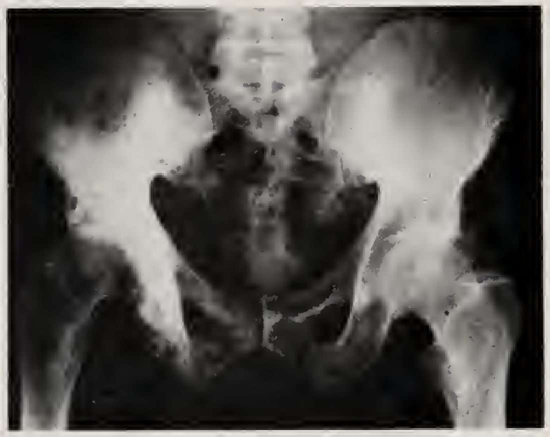

FIG. 8. Decrease in osteophytes, increase in bone sclerosis and sharp demarcation of bone (compare with fig. 3) after penicillin therapy.

will occur and the physician should be on the alert. An early and accurate diagnosis with institution of modern chemotherapeutic measures can bring about great improvement and many cured cases. An inaccurate diagnosis and incorrectly treated case will terminate in most instances in unwarranted serious sequelae.

SUMMARY

1. The recent literature has been reviewed and from this one would assume that acquired syphilitic bone disease (symptomatic or asymptomatic) occurs in only 0.5 to 0.7 per cent of syphilitic cases.

2. A case of acquired symptomatic generalized syphilitic bone disease is reported.

3. The interesting features in this case were the differential diagnosis, the multiplicity of involvement, and the response to penicillin therapy.

BIBLIOGRAPHY

1. BORTZ, E. L.: Bone syphilis, in Cyclopedia of Medicine, Surgery, and Specialties. Philadelphia: Davis, 1939, **3,** 5.
2. BUCHMAN, J.: Frequency of syphilis of bones and joints. Urol. & Cutan. Rev., 1945, **49,** 22.
3. BUCHMAN, J., AND LIEBERMAN, H. S.: Prevalence of syphilis of bones and joints; report of statistical study at Hospital for Joint Diseases, with review of literature. Arch. Dermat. & Syph., 1941, **44,** 1.
4. FRANCIS, H. C., AND KAMPMEIER, R. H.: Bone lesions in acquired tertiary syphilis. South. M. J., 1943, **36,** 556.
5. MOHR, C. F., AND OTHERS: Syphilis; review of recent literature. Arch. Int. Med., 1944, **74,** 457.
6. BAILEY, G. G.: Manifestations of bone syphilis. Urol. & Cutan. Rev., 1945, **49,** 11.
7. WENGER, H. L.: Syphilis of bone. Ibid., 1945, **49,** 29.
8. STOKES, J. H., AND OTHERS: Action of penicillin in late syphilis including neurosyphilis, benign late syphilis and late congenital syphilis; preliminary report. J. A. M. A., 1944, **126,** 73.
9. EASLEY, E. J.: Brief summary of modern concepts of acquired syphilis. J. Arkansas M. Soc., 1945, **41,** 183.

PERFORATING WOUND OF ORBIT

Report of a Case

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The patient, T. H., aged 3 years, was apparently sitting in a rocking chair on the porch when the chair tipped back and he fell a distance of 3 or 4 feet into a bush by the porch. His face was scratched and he sustained an injury to his left eye. He was rushed to Episcopal Eye, Ear and Throat Hospital and admitted in a state of shock. Unimportant foreign debris was removed from the left nostril; the face was cleansed, and it was found that the left upper lid had sustained a perforating wound, from which a number of small pieces of wood and bark were removed. Superficially the eye did not appear to be injured. However, shock was the main concern at that time, and supportive measures were immediately taken to combat that condition.

The rectal temperature ranged from 103° F. to 104.8 F. The pulse rate ranged from 118 to 158. The respiratory rate was 24. The general condition was poor, the patient restless and drowsy. The upper lid of the left eye was swollen and edematous, with a ragged perforating wound at the junction of the inner and middle thirds, which was filled with serum and clotted blood. The lid was immobile. The conjunctiva was only slightly congested. The eye ball was fixed. There was no injury to the anterior portion of the eye. The cornea was free of abrasions, mildly steamy and anesthetic. The pupil was fixed and partially dilated. There were no pupillary reactions. The media were clear. The fundus, including the nerve head, was congested, but not markedly so. There was no edema about the disc.

On the second day the nerve head became quite edematous. There were no intra-ocular hemorrhages. On the third day the general condition improved; the temperature and pulse rate showed only slight elevation with the temperature reaching a high of 102° F. However, the outer appearance of the left eye showed a marked reaction. The lids swelled and the conjunctiva became markedly swollen and congested. After deeper probing into the wound with a small, blunt hemostat, free pus was evacuated and sulfonamide powder was forced into the wound.

During the next 10 days very little change occurred in the general condition of the patient. He appeared to be improving daily. He was active and playful and appeared to be in no pain. The temperature ranged from 100° F. to 102° F., and he slept well at night. In some of the probing, pus was evacuated, indicating that there was a possibility of a foreign body still remaining in the wound. At the apparent base of the wound, a depth of approximately 2 inches, a slight roughness could be felt. It had the feeling of roughened bone or torn periosteum. Another resistant "splinter" could be encountered along the wall of the wound. Occasionally the splinter was lightly grasped to determine if it could be worked out, but it seemed quite fixed until about the tenth day after the accident, when it was grasped and withdrawn easily. It was a piece of twig. Then the rough body at the base of the wound was grasped with somewhat more confidence, and it slipped out with very little resistance. It was a twig 2⅜ inches long and about the thickness of a pencil. The proximal end was 1⅝ inches from the mouth of the wound on the skin of the upper lid, which made its distal end 4 inches from the outer lip of the wound.

Assuming that the orbit is 2 inches deep, this foreign body penetrated the cranial cavity a distance of approximately 2 inches. Its course may have been as follows: It penetrated the upper lid, grazing the eye ball, where the tough sclera turned the twig upward and backward. In passing backward and possibly medially, it struck the optic nerve, injuring that structure with its sheath and following the optic nerve to the optic foramen. Here it met resistance in the dense bony structure surrounding the foramen, caromed upward through the superior orbital fissure, and injured the muscle cone about the optic nerve and foramen as it entered the fissure. As it passed into the cranial cavity it destroyed the third nerve, and possibly the fourth, the ophthalmic branch of the fifth, the sixth, and possibly some sympathetic fibers, but fortunately it did not injure the large orbital branches of the middle meningeal artery nor the ophthalmic vein, nor the recurrent branch from the lacrimal artery to the dura mater. As far as could be determined, the distal end of the twig reached the area known as the interpeduncular fossa, a rhomboidal space bounded by the pons, the cerebral peduncles, and the optic tracts. Figures 1 and 2 show the probable course of the twig.

The patient was discharged from the hospital on the twenty-seventh day as completely recovered, although it was deemed advisable to keep him under frequent ob-

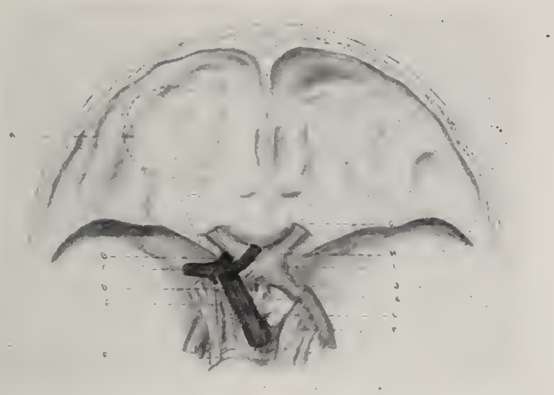

FIG. 1. Probable course of foreign body. A—Eyeball; B—internal carotid artery; C—middle cerebral artery; D—ophthalmic branch of fifth nerve; E—fourth nerve; F—pons varoli; G—optic foramen; H—anterior cerebral artery; I—optic chiasma; J—infundibulum; K—foreign body; L—third nerve; M—peduncle.

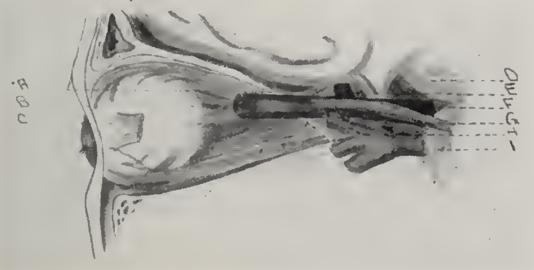

FIG. 2. Probable course of foreign body. A—Superior orbital fissure; B—foreign body; C—optic nerve; D—peduncle; E—infundibulum; F—third nerve; G—fourth nerve; H—ophthalmic branch of fifth nerve; I—pons varoli.

servation for possible ocular or intracranial complications. These did not develop. The eye "quieted down" but the nerve head became white, there was no vision in the eye, and the eyeball remained fixed and anesthetic. Drainage from the wound ceased within a few days, but from time to time the wound had a tendency to break down and discharge for a few days. Occasionally the conjunctiva would become congested, but this condition usually followed a cold.

About 9 months after the injury the patient developed a trophic ulcer of the cornea of the left eye. This followed a severe head cold, and the patient's general condition did not look good. The entire eye showed marked reaction, and enucleation, which had been considered for many months, was performed. This operation followed consultation with a neurosurgeon and other ophthalmologists. Among the various examinations was an X-ray examination after the injection of opaque fluid into the old wound. However, nothing specific was observed with regard to intracranial complications. The patient recovered rapidly from the enucleation. He has been wearing a prosthesis now for over a year, and his general condition indicates complete recovery.

Several features of this case are remarkable: (1) No intracranial complications developed; (2) the foreign body completely anesthetized the eye and fixed it so that it was 100 per cent immobile; (3) none of the larger vessels was punctured; (4) the eye was lost, but that was a small loss when one considers the general condition of the patient during the first 12 hours, and the extent of the injury; and (5) X-ray examination failed to reveal a foreign body and any bone injury.

CLINICO-PATHOLOGIC CONFERENCE*

GEORGETOWN UNIVERSITY MEDICAL DIVISION OF GALLINGER MUNICIPAL HOSPITAL
Conducted by
CHARLES F. GESCHICKTER, M.D.
Professor of Pathology, Georgetown University School of Medicine
HAROLD J. JEGHERS, M.D., F.A C.P.
Professor of Medicine, Georgetown University School of Medicine

DR. JEGHERS: Copies of the following case history were distributed to all students a week ago. The correct diagnosis of cases in these conferences is not known to the student body or the discusser. Dr. Paul R. Wilner is our guest discusser today.

CASE HISTORY

The patient, a 29-year-old single white female, was admitted to the hospital on July 8, 1945, complaining of severe chills, fever and pain in her left shoulder. Her illness started 3 days before admission with generalized aches, severe chills and a fever of 100°F., with accompanying nausea and vomiting. The following day she had a dull aching pain in her left shoulder with occasional sharp exacerbations. The vomiting and generalized ache subsided, but she lost her appetite and developed some pain in her left elbow on moving that joint. The next day the right wrist ached. The patient was menstruating on admission. Her last menstrual period had been 8 weeks previously. Pregnancy and veneral disease were denied. She had had no stools since the onset of her illness.

On admission the temperature was 104°F., the respiratory rate 30, and the blood pressure 120/70. The left ear drum was slightly injected. There was a small bleeding area in the right nasal septum, and foul breath was noted. There was no lymphadenopathy. The breasts were engorged. The lungs were clear. The heart rate was 128. The cardiac rhythm was regular. There was a nontransmitted apical, grade 2, blowing, systolic murmur. The abdomen was negative except for slight lower abdominal tenderness. The left shoulder and arm were held immobile close to the body. There was slight tenderness of the acromial joint. The left elbow was slightly painful on hyperextension but otherwise negative. There was slight pain on moving the right wrist.

X-ray examination of the left shoulder was negative. A roentgenogram of the chest shortly before death revealed bilateral patchy consolidations in the lungs. A blood culture, taken on July 10, 1945 and reported the day after death, showed Staphylococcus aureus. A sedimentation rate was 28 mm. per hour. Electrocardiograms showed sinus tachycardia. The blood urea nitrogen was 16.1 mg. per cent. The blood sugar was 87 mg. per cent. Complete blood count on July 8, 1945 showed the red blood cells to number 4,300,000 and the white blood cells, 8,500, with 89 per cent segmented forms; the hemoglobin was 10 Gm. There was heavy toxic granulation in the white blood cells. On July 9, 1945 the red blood cells numbered 3,300,000 and the white blood cells, 12,600, with 72 per cent segmented forms, 15 per cent band forms, and 4 per cent juvenile forms; the hemoglobin was 9.8 Gm. On July 12, 1945 the red blood cells numbered 3,100,000 and the white blood cells, 9,300, with 68 per cent segmented forms, 15 per cent band forms, and 6 per cent juvenile forms; the hemoglobin was 9.0 Gm. Urinalysis showed the specific gravity to be 1.010, the reaction acid, albumin of 15 mg., sugar of 500 mg.; and the presence of white blood cells and red blood cells, too numerous to count.

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* This Conference was held at 12:00 Noon, Friday, February 14, 1947, in the Medical Auditorium of Gallinger Municipal Hospital for members of the third-year class.

Improvement of the joint pain followed administration of intravenous glucose and salicylates. The fever continued between 101°F. and 104 F. Two days after admission there was a sudden occurrence of an acute pain in the left side of the chest with dyspnea and cough. The fever continued, ranging from 100°F. to 101°F., the pulse rate being 120. The heart murmur continued to be heard. The abdomen was slightly distended and tympanitic. The following day the fever ranged from 99°F. to 101°F. The blood pressure was 110 60. The dyspnea was less, although the mouth was dry; the abdomen remained distended, although there were normal bowel movements. On July 12, the fifth day after admission, the dyspnea became more marked. There were râles in the right and left lower lung fields. The pulse rate was 140, the blood pressure was 90/60, and there was a slight cyanosis. The pulse became irregular, the patient became irrational, and the blood pressure dropped to 84/56. Treatment included use of the oxygen tent, plasma transfusion, and the administration of parenteral fluids, penicillin and salicylates. In spite of intensive therapy the patient died on July 12, 1945.

DIFFERENTIAL DIAGNOSIS

DR. WILNER: Since you have already read the record of this case, I shall recapitulate only the more pertinent features.

The patient was a 29-year-old white female. It must be remembered that things happen to a 29-year-old woman that might not happen to a younger or an older woman and that could not happen under any circumstances to a member of the male sex. The facts of her age and sex may therefore be important. It is obvious that the disease began acutely and that joint manifestations were prominent almost from the start. The left shoulder and elbow and the right wrist were painful and tender, but there is no mention of their being hot, red, or swollen. The joints were involved more or less simultaneously, and the trouble does not suggest a migratory arthritis. X-ray examination of the left shoulder was negative, but this means nothing early in the course of joint disease. Evidence of damage in roentgenograms may be a very late development in some serious forms of arthritis, and in others, like acute rheumatic fever, there may never be any changes in the X-ray films. In this case the joint symptoms were relieved by salicylates, which is characteristic of acute rheumatic fever. Presumably the salicylates were given intravenously, although this is not clearly stated and the dose is unknown. Usually the dose is 10 grams a day for acute rheumatic fever. However, the relief of the joint symptoms by means of salicylates does not prove a diagnosis of rheumatic fever because a similar effect can be obtained in other forms of joint involvement.

I believe that this patient was pregnant because there was a history of amenorrhea and the breasts were engorged. The fact that she was single does not eliminate pregnancy. Presumably the pregnancy was an early one. At the time of admission to the hospital there was vaginal bleeding, which brings to mind several possibilities. Many acute fevers can cause abortion. On the other hand, the bleeding may have antedated the illness, or there may have been a reason for the illness because of an abortion. We are not told much about the bleeding. We are forced to wonder therefore whether or not there was an infected abortion, and if so, whether it was complicated or uncomplicated.

The description of the course of the fever suggests that it was septic until the very end, and there was an accompanying tachycardia. This latter fact is somewhat against such diseases as typhoid fever and influenza, in which the pulse rate is usually disproportionately slow. However, there are a great many causes for fever which cannot be immediately excluded from consideration. The absence of lymphadenopathy and the fact that the lungs were clear initially may be of some help in directing our thoughts.

There was a grade 2, blowing, systolic murmur at the apex. Of course, the grading of the intensity of a murmur is very much an individual problem, but I believe we shall have to accept the idea that this may have been an organic murmur. However, fever, anemia, and tachycardia all were features of this case and in combination might have produced a functional murmur of this intensity. There was no previous history of acute rheumatic fever or of a rheumatic equivalent, and it seems improbable to me that this was rheumatic heart disease. There is no mention of any change in the character of the murmur which would have been suggestive of subacute bacterial endocarditis, or of acute bacterial endocarditis for that matter.

Five days after the onset of the illness there was sudden chest pain accompanied by dyspnea and cyanosis. The description does not suggest cardiac pain. Probably this episode was due to a pulmonary embolus or infarct. The pain was brief, and we cannot be certain about the extent of pulmonary involvement from the physical examination. However, a chest film made shortly before death showed bilateral patchy consolidation of the lungs, and this description is consistent with multiple infarcts. Many pulmonary infarcts are "silent," and when they occur in the course of an acute infection there may be few symptoms, and the X-ray examination may be equivocal or even negative. In the case of this patient, the evidence for infarction seems rather conclusive.

The patient's abdomen was distended and tympanitic, but there was no intestinal obstruction judging from the fact that the bowels moved satisfactorily. Any severe infection could produce these abdominal findings.

The terminal episode appears to have been due to a combination of pulmonary and cardiac causes with overwhelming toxemia. It is noteworthy that the patient remained mentally alert during the illness, which is not at all like typhoid fever or malaria.

The laboratory studies showed an anemia that was rapidly progressive. The erythrocyte count dropped more than a million in 4 days. Many things might account for such a change. It is seen during various infections, especially if there is an attendant factor of hemolysis. The fact that the patient was not jaundiced makes the idea of a hemolytic effect unlikely. On one occasion there was a high white blood cell count; the other times it was not high. However, on each occasion the percentage of neutrophils was high and there was a shift to the left. This finding, in the presence of a normal total leukocyte count, signifies overwhelming infection, and the toxic granules representing degenerative changes in the white blood cells are consistent. The urine showed many white and red blood cells, but this may have been due to contamination of the specimen from the vaginal discharge if the specimen was not obtained by catheterization. Assuming that it was a catheterized specimen, we are led to believe that there was involvement somewhere in the urinary tract, perhaps only cystitis or perhaps renal disease. The test for albumin was positive, but this may or may not be significant, since it could be due to the fever and the increased cellular content of the urine. There was also sugar in the urine, the amount being 0.5 per cent, but we don't know whether the specimen was obtained before or after an intravenous infusion of glucose solution. Since the level of the blood sugar was normal, I suppose that it was due to an injection of glucose.

A blood culture was positive for Staphylococcus aureus. The organism is not further classified. We would like to know whether or not it was coagulase-positive, a finding which usually signifies virulence. Of course, the organism may have been a contaminant, although the Staphylococcus albus is a more common offender in this respect. We shall have to trust the laboratory on this finding. If it had been discovered in a case of coronary thrombosis or brain tumor we might give it little attention.

Here it fits in too well with the rest of the picture to be disregarded.

Electrocardiograms showed sinus tachycardia. Apparently there was no evidence of cor pulmonale or of myocardial changes that might accompany rheumatic fever.

The erythrocyte sedimentation rate was somewhat elevated. The only thing this brings to mind is to wonder why the test was done. It certainly affords no additional information.

Now, taking all of the features of the case into consideration, the only thing obvious is that there was some kind of acute overwhelming infection. It remains to be seen whether everything can be attributed to one cause.

Remembering that there was joint involvement, fever, tachycardia, and leukocytosis, we must consider acute rheumatic fever. The disappearance of the joint pain after administration of salicylates already has been mentioned. It is possible that the pulmonary involvement represented rheumatic pneumonia. The abdominal symptoms and the urinary findings are not incompatible with the diagnosis. However, the joints were not typical for rheumatic fever, and the trouble was not migratory. In addition, the patient was 29 years old and there was no previous history of rheumatic fever, which would be unusual. Also this disease was rapidly fatal, and this is not usually the case in rheumatic fever. When rheumatic fever is fatal, signs of heart failure may be expected to dominate the picture, which certainly was not true for this patient. The electrocardiograms were not significant, and the description of the murmur leaves us undecided. Actually, it is hard to be perfectly sure that this was not acute rheumatic fever, but I don't believe it was.

The diagnosis of malaria must be considered briefly. In this disease the usual cause of death is cerebral involvement with coma or stupor. Patients with severe malaria may have pulmonary involvement, but leukopenia, discovery of the parasites, and splenomegaly are to be expected. The type of fever is no help; some patients have no fever, and in others the temperature curve is bizarre. The diagnosis of malaria has little for its support, although malaria complicated by staphylococcal septicemia cannot be excluded.

Miliary tuberculosis is a possibility but there is nothing particularly supportive of this diagnosis. Typhoid fever would be expected to run a longer course before there would be death from toxemia, and longer still before there would be a complication like hemorrhage or perforation. The mental alertness of the patient and the rapid pulse are other points against typhoid. Acute brucellosis usually runs a longer course also, and is brought to mind only because of the abortion in this case. Tularemia might be suggested by the description of the pulmonary lesions, but there was no apparent source of entry for this disease. Subacute bacterial endocarditis ordinarily lasts much longer than in this case, and we would expect the blood culture to be positive for Streptococcus viridans rather than Staphylococcus aureus. In addition, there were no embolic manifestations in the systemic circulation. Acute bacterial endocarditis is unlikely, if for no other reason, because it is rarely a disease in itself. The rickettsial diseases, polyarteritis nodosa, and disseminated lupus erythematosus should be kept in mind in any case of obscure fever. There is, however, nothing to suggest any of these diseases.

I believe the patient had septicopyemia due to the Staphylococcus aureus. This is a rapidly fatal disease having an acute onset and just this kind of septic course. Joint manifestations are common, as are the progressive anemia, changes in the white blood cell count, positive blood culture, and evidence of metastatic lesions. Since this is my diagnosis, I must try to explain how or where the disease had its start. The usual entry is by way of the skin, but our patient had no furuncles and there were no puncture marks to suggest that she was a narcotic addict. The respiratory tract may be the portal of entry.

The record mentions that the left ear drum was injected, but this is hardly enough. A draining ear might have told another story. There is nothing else to incriminate the respiratory tract. Osteomyelitis may be the initiating lesion, but the only thing to suggest musculoskeletal disease in this patient was the minor joint involvement which did not precede but accompanied the fatal illness.

Another portal of entry is from pelvic infection, and this may be the crux of the situation in our patient. It is quite probable that she had a septic abortion going on to the tragic sequel of septicopyemia. The infection would have extended from the uterus to produce septic thrombophlebitis of the pelvic veins, and then the disease would run the gamut of metastatic staphylococcic lesions. Unfortunately a pelvic examination was not done. The fact that abdominal symptoms are no more prominent in the history means little. There may be only slight local abdominal tenderness with even the most virulent infected abortion. The pulmonary lesions must have been septic infarcts on the basis of pelvic thrombophlebitis. The urinary findings, if they are reliable, probably indicate that there was pyelonephritis or even renal abscesses. The cardiac murmur may have represented acute endocarditis.

In conclusion, then, my diagnosis in this case is infected abortion, local peritonitis, pelvic thrombophlebitis, and staphylococcic septicopyemia with metastatic lesions in the lungs, and kidneys, and possibly also in the heart.

Dr. Jeghers: Thank you, Dr. Wilner, for a most interesting discussion. Would anyone in the audience care to add another opinion? If not, may we hear what diagnoses were handed in by members of the third year-class.

Dr. Jacquet: Eighty-one students submitted diagnoses. Tabulation of the major diagnoses were: abortion with septicemia 38, acute bacterial endocarditis 32, acute rheumatic fever 8, and ruptured ectopic pregnancy 3.

Dr. Jeghers: Dr. Geschickter will now present the pathologic findings noted at postmortem examination.

Dr. Geschickter: I would like to add a few additional observations to the clinical picture. When this patient was originally seen the cardiologist was consulted. He considered the possibility of an atypical rheumatic fever. The patient repeatedly denied the possibility of pregnancy. Pelvic examination was omitted because the patient was "menstruating." Within a short time, however, the presence of a septicemia became apparent.

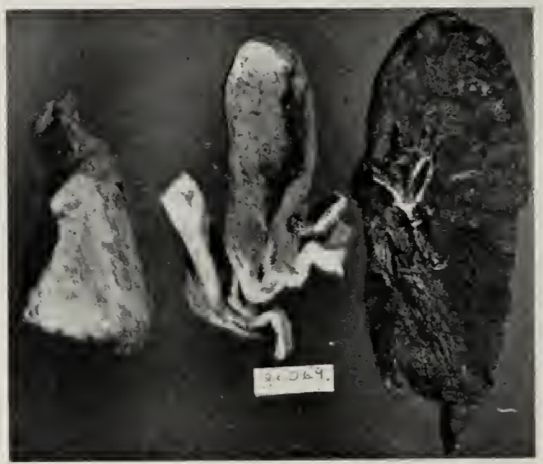

Fig. 1. Cross sections of breast, uterus and lung from left to right.

At postmortem examination the breasts when incised exuded milky fluid. The texture was consistent with lactation hypertrophy. There was no peritonitis or empyema.

The colored slide now on the screen shows the gross appearance of the uterus (fig. 1). The cervix is boggy, the uterine walls are thickened, and the uterine cavity is studded with the thrombosed ends of numerous dilated veins. On the posterior wall there is a deposit of fibrin, and near the junction of corpus and cervix there is a zone of slough posteriorly, measuring 3 cm. in diameter. The left uterine vein is thrombosed. A portion of the thrombus is suppurating.

The uterine infection resulted from an illegal abortion. This was the initial focus of infection in this patient. Bacteria from the endometritis spread rapidly through the uterine wall via the uterine veins and thrombophlebitis resulted. From here detached, septic emboli spread to various parts of the body and caused a generalized septicemia.

The colored slide also shows the lungs in cross section. Note the septic infarcts, which show in cross section as grayish light areas against the dark, hemorrhagic background of pulmonic tissue. Infected emboli were scattered through both lungs. However, pleuritis or empyema had not yet developed. These complications, as well as pulmonary abscess, may follow infected pulmonary infarcts.

Gross examination of the heart shows fibrin strings on the valves and small petechiae on the epicardial surface. There are early vegetations on the aortic and mitral valves and small, septic infarcts in the myocardium.

The colored slide shows the cross section of one of the mammary glands. Note the large amount of white, succulent parenchyma. The breast is lactating. There was an acute splenic tumor. The kidneys escaped severe embolic involvement.

Microscopically the lungs showed beginning confluent bronchopneumonia and multiple septic infarcts, some with suppuration. This is shown in the microphotograph. The alveolar walls are breaking down in the septic areas. This second section shows pus and hemorrhage in the posterior uterine wall, and the next section the infected thrombus in the left uterine wall. Staphylococcus aureus was obtained on culturing.

The primary anatomic diagnosis was septic abortion with thrombophlebitis of the left uterine vein. Secondary anatomic diagnoses were Staphylococcus aureus septicemia, multiple septic infarcts of lung and myocardium, terminal bronchopneumonia, early vegetative endocarditis, acute splenic tumor, corpus luteum cyst, and pregnancy changes of the uterus and mammary glands.

Dr. Jeghers: This has been a most instructive case. One important lesson stands out, namely, the difficulty of evaluating the denial of pregnancy in a case of this type. It is well always to consider the possibility of the uterus being the source of infection when a woman in the child-bearing age shows a clinical picture consistent with septicemia, endocarditis, or septic emboli to any organ.

The initial phase of this patient's illness, because of the acute involvement of the several joints along with a heart murmur, strongly simulated acute rheumatic fever.

Modern sulfonamide and antibiotic therapy are strikingly changing the statistical analysis regarding the frequency of the cause of death as a result of complications following criminal abortion and puerperal infection. The most reliable statistics are in the older literature, and based on the writings of Martland,[1] Kneise,[2] and others, an approximate evaluation of the causes of death would be:

	Per cent
Peritonitis	50
Thrombophlebitis	30–40
Putrid endometritis (gas anaerobes)	10
Uterine erysipelas (lymphatic spread)	0–2
Hemorrhage	10
Air embolism	0–1
Oil embolism	0–1
Kidney damage due to chemicals absorbed from the uterus	0–1

Note that peritonitis and pelvic thrombophlebitis together make up most of the cases. Noninfectious causes are no doubt more prevalent now than when these figures were published.

An important cause of the failure to diagnose septicemia is the failure to obtain a positive blood culture. Careful attention to a few details will greatly improve the percentage. These rules are: (1) attention to sterile technic,

(2) taking of blood for blood culture 1 or 2 hours before the height of a chill or febrile peak if the time of their occurrence is regular enough to predict in advance (cultures made during or shortly after a chill are usually not worth while), (3) incubation of all blood culture flasks for at least 1 week before discarding, (4) growing some media under anaerobic conditions, (5) repeating all negative blood cultures, (6) taking several blood cultures during a 24-hour period which occasionally may yield a positive when the same number taken 1 each day will not, since bacteria do not multiply in the blood ordinarily but are periodically showered into the vascular system from active primary or metastatic foci, (7) repeating all positive cultures of common organisms, i.e., Staphylococcus albus, B. coli, diphtheroids, etc., to be sure they are not contaminants, (8) if necessary, using substances such as para-aminobenzoic acid, penicillinase, etc. in the culture media to counteract the influence of the therapeutic agent the patient may be receiving, and (9) taking an initial blood culture prior to the onset of therapy if possible.

Puerperal infections may result from criminal or other types of abortion, as well as follow full-term deliveries. Similar clinical pictures can result from any of these. Inadequate history of pregnancy frequently makes the diagnosis difficult, as is well exemplified in the case discussed today.

Puerperal infection results from bacterial invasion of gross or microscopic puerperal wounds of the uterine cavity or cervix and occasionally of the vagina or perineum. The various clinical syndromes which result from puerperal infection have been succinctly described and illustrated by Martland[1] in a paper which I strongly urge each student to read. Martland's illustrations and the legends describing them will be shown on the screen and a few comments made about each of the syndromes depicted.

Figure 2 depicts the lesions of acute puerperal peritonitis which is the common cause of death in puerperal infection and septic abortion. The clinical picture is essentially one of acute generalized and more rarely localized peritonitis. The legend beneath figure 2 lists the various mechanisms whereby peritonitis results.

Septic thrombophlebitis is the second most common form of death in puerperal infections and according to various statistics is responsible

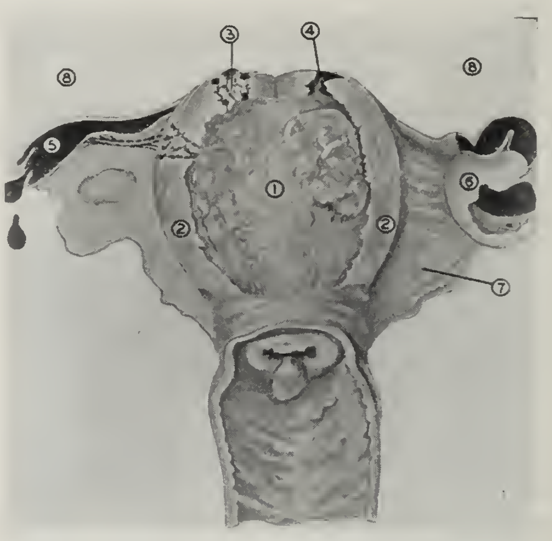

Fig. 2. Acute Puerperal Peritonitis

Summary of Lesions

1. Puerperal endometritis
    Septic endometritis the primary lesion.
    Occasionally a puerperal ulcer.
2. Metritis
    The underlying muscle may show only microscopic involvement, or there may be multiple abscesses or a gangrenous endometritis.
3. Extension of infection direct to peritoneum by lymphatics of uterine wall with production of peritonitis
    This is probably the most common way in which the peritoneum becomes infected, the subserosal abscess being an important factor.
4. Extension of infection direct to the peritoneum by uterine trauma induced by instrumentation
    Rupture of uterine wall caused by instrumentation.
5. Extension of infection to peritoneum by continuity through lumina of fallopian tubes
6. Production of a salpingitis or tubo-ovarian abscess with localized peritonitis
7. Extension of infection to pelvic cellular tissues
    With formation of parametritis, pelvic abscess, etc.
8. Peritonitis
    Localized and generalized.

(Reprinted from Martland[1] with permission of the author and the Am. J. Surg.)

for 30 to 40 per cent of the fatal cases. Infection spreads outward through the veins of the uterine wall with resulting infected thromboses. The mechanisms of spread are well shown in figure 3. Symptoms are often delayed a week or more since it requires time for bacteria to loosen clots. The onset is abrupt, often with a chill followed by an acute or chronic septic febrile course with signs of infection localized to one or more organs, particularly the lungs. The primary vein infection or secondary embolic septic foci shower organisms into the blood unless the bacteria are filtered out in the lung capillaries. The wide variety of metastatic lesions which may result are admirably depicted in figure 3.

Bacteria and septic emboli may reach the arterial circulation and produce one or more of the lesions shown in figure 4. Positive blood cultures are very likely to result at this stage. The patient under discussion today had many of the lesions shown in both figure 3 and figure 4. Although the joints were not examined in our patient, multiple emboli to shoulder, elbow, and wrists (see figure 4) could account for the acute arthritis. Naturally an X-ray film at this early period would be reported as negative.

A rare type of puerperal infection is uterine erysipelas, sepsis foudroyant, or acute lymphatic sepsis, as it has been variously called. All cases are due to hemolytic streptococcus with spread up the lymphatic system as shown in figure 5. After a short incubation period of 36 hours or

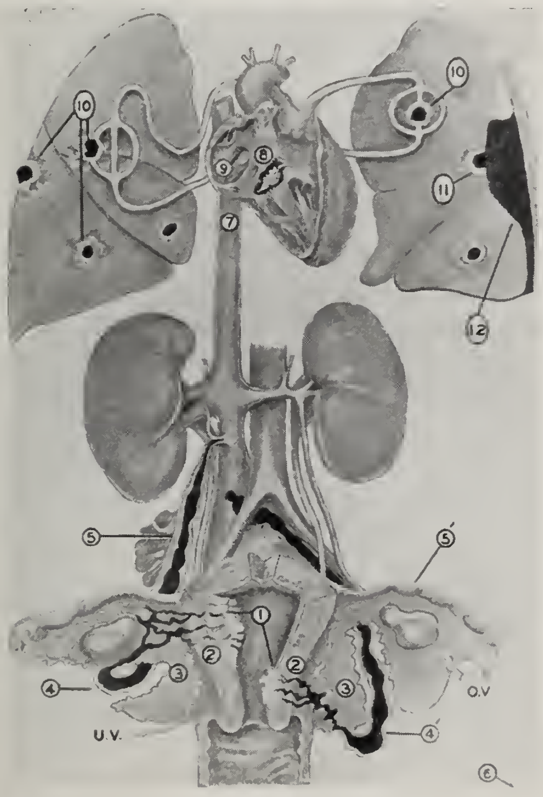

FIG. 3. THROMBOPHLEBITIS

Summary of Lesions Due to Infection of Veins

1. Infection of endometrium at placental site
   Two different cases are illustrated in the figure. On the right side (left side of figure) the infection is situated in upper uterine zone. In this location, the thrombophlebitis is more apt to extend to the ovarian vein. On the left side (right side of figure) the infection is in lower uterine segment and extends to uterine vein.
2. Thrombophlebitis of uterine wall
   Note localized and unilateral character.
3. Thrombophlebitis in broad ligament
   Note unilateral location.
4. Extension of thrombophlebitis to ovarian vein
   Note unilateral involvement only.

4′. Extension of thrombophlebitis to uterine and internal iliac veins

5. Periphlebitis of the ovarian vein—retroperitoneal abscess

5′. Production of pelvic cellulitis and retroperitoneal and extraperitoneal abscess

6. Phlegmasia alba dolens
   Due to retrograde venous infection.
   For other causes see text.
7. Infection carried to right side of heart
8. Acute bacterial endocarditis of tricuspid or pulmonic valves
   This is an unusual occurrence.
9. Paradoxical embolism
   Emboli to systemic arterial circulation through a patent foramen ovale.
10. Embolic, hematogenous abscesses of lungs
   This is the most important and characteristic secondary lesion of thrombophlebitis cases, whatever their cause.
11. Subpleural abscess infecting pleura by contiguity or rupture
12. Empyema
   From infection by close proximity of lung abscess.

No peritonitis in these cases.

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more the onset is abrupt with a chill, fever, headache, and prostration. Untreated, the course is short and fulminant.

Putrid endometritis is another and by no means rare clinical syndrome in the group of fatal puerperal complications under discussion. Putrefactive bacteria (colon bacilli, anaerobic cocci and gas-producing anaerobes, i.e., B. welchii) are responsible. Spread from the uterus can cause peritonitis or gas septicemia with a rapidly fatal course. In the latter, general systemic infection causes a fulminating course and clinical picture characterized by an acutely conscious mental condition, rapid pulse, deepening jaundice, methemoglobinemia and cyanosis, pain over the uterus and foul vaginal discharge often containing gas.[3, 4] The combination of methemoglobinemia, anemia and jaundice produces a peculiar bronze or mahogany color of the skin in the advanced severe cases.

It is well to emphasize at this point that the aforementioned infectious puerperal complications are nowadays frequently but not always successfully treated with such therapeutic agents as the sulfonamides and the antibiotic agents. The importance of their early recognition and particularly their prophylaxis deserves your careful consideration. The common organisms causing puerperal infection are: (1) the hemolytic streptococcus, (2) Staphylococcus aureus, (3) nonhemolytic and anaerobic streptococci, (4) B. coli, and (5) Cl. welchii.

Rarely tetanus may appear as a form of puerperal infection.[5]

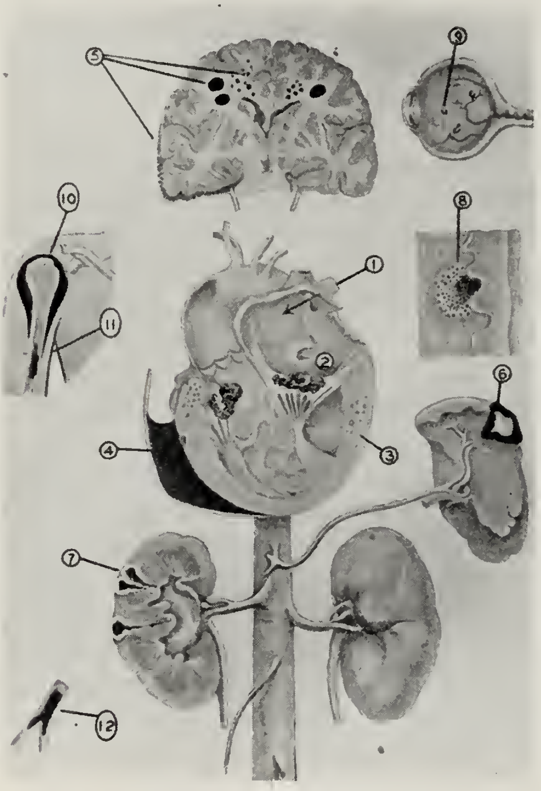

FIG. 4. THROMBOPHLEBITIS

Summary of Lesions Due to Infection of the Arterial Circulation

1. Organisms enter left auricle via pulmonary veins
2. Acute bacterial endocarditis of the mitral or aortic valves
3. Emboli to myocardium
   Via coronary circulation. Microscopic if due to streptococci. Distinct naked eye abscesses if due to staphylococci.
4. Extension of infection to pericardium
   Subpericardial abscess infecting pericardium by contiguity or rupture with production of a serofibrinous pericarditis, or empyema of pericardium.
5. Emboli to nervous system
   With production of petechial hemorrhages due to septic emboli; large cerebral hemorrhages due to septic thrombosis of larger vessels; multiple, usually small, brain abscesses and suppurative meningitis.
6. Splenic infarcts
   Typical wedge-shaped infarcts or purulent abscesses. Localized perisplenitis and rarely perisplenic abscess.
7. Renal infarcts
   Isolated infarcts; suppurative embolic nephritis; perinephric abscess.
8. Cutaneous and mucous membrane emboli
   In conjunctivae, skin and mucous membranes. At autopsy in pleura, pericardium and peritoneum. Raised liquefied centers in staphylococcus infections.
9. Embolic lesions in eyes
   Retinal petechiae and rarely panophthalmitis.
10. Embolic lesions in joints
    Suppurative arthritis most common in shoulders, elbows and knees. Pyemia.
11. Osteomyelitis
12. Embolic lesions in arteries
    Arterial occlusion in peripheral arteries with gangrene. Mycotic aneurysms. Many of these lesions often keep up the sepsis after the original source has entirely healed and disappeared. Even secondary and tertiary lesions may act as primary ones, many months later.

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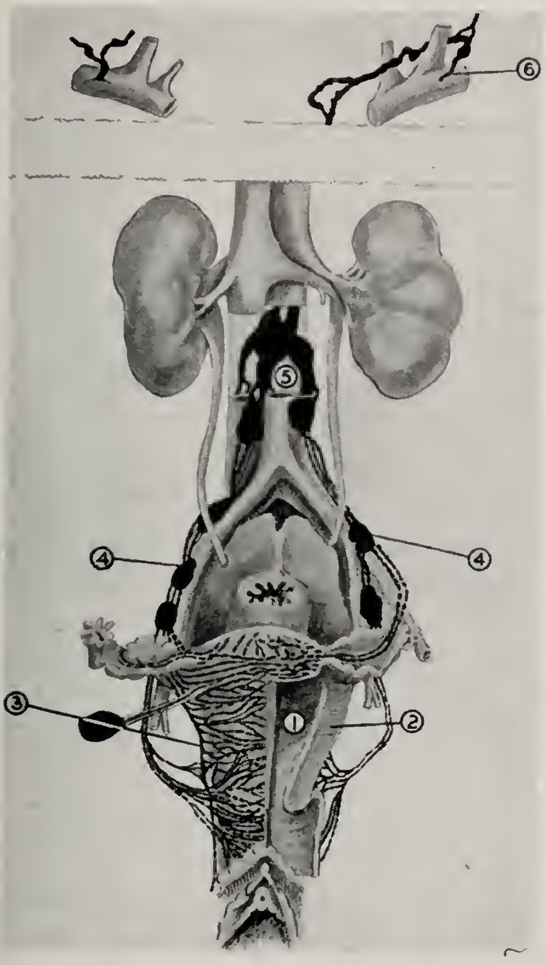

FIG. 5. UTERINE ERYSIPELAS

Acute Lymphatic Sepsis (Tweedy and Wrench); Sepsis Foudroyant (Williams et al)

Summary of Lesions

1. Infection of endometrium with streptococci
   The uterus is slightly enlarged, clean, boggy, red and edematous. Its endometrium is smooth and glistening.
2. Drainage into lymphatics of uterine wall
3. Drainage into lymphatics of broad ligaments
   The process is bilateral, uniform and symmetrical.
4. Drainage into regional lymph nodes, of pelvis and pelvic brim
   The glands are swollen, edematous, pale and distended with watery fluid containing innumerable streptococci.
5. Drainage into lumbar lymph nodes and thoracic duct
   Rapid death, from toxemia, results in nearly all cases.
6. Drainage into left subclavian vein
   Patients usually die before this occurs.
7. Other lesions due to toxemia
   Acute cloudy swelling of heart muscle, liver and kidneys, and acute septic spleen. No emboli and no peritonitis in these cases.

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Manipulations of the uterus or injection of various materials (including air or oil) into it (even for therapeutic purposes) may occasionally be serious or fatal. It is often overlooked that air embolism,[6, 7, 8] fat embolism,[9] or chemical poisoning [9] may occur in this manner. Rarely late in pregnancy or at term, fatal embolism may result from particulate matter in the amniotic fluid and meconium.[10]

Hemorrhage caused almost 10 per cent of deaths in suspected criminal abortion reported by Martland.[1] The clinical features and treatment of this complication need not be discussed further at this time.

BIBLIOGRAPHY

1. MARTLAND, H. S.: Puerperal infection, with special reference to importance of anatomical pathways in spreading of pyogenic infection. Am. J. Surg., 1934, **26,** 90.
2. KNEISE, cited by Martland (see ref. 1).
3. RENDLE-SHORT, C.: Clostridium welchii infection of uterus complicating delivery. J. Obst. & Gynaec. Brit. Emp., 1942, **49,** 581.
4. RUSSELL, P. B., JR., AND ROACH, M. J.: B.welchii infections in pregnancy, with review of literature and report of 17 cases. Am. J. Obst. & Gynec., 1939, **38,** 437.
5. Report of Tetanus Committee, Royal College of Obstetricians and Gynecologists: J. Obst. & Gynaec. Brit. Emp., 1941, **48,** 394.
6. GORDON, I.: Fatal air embolism in criminal abortion. Clin. Proc., 1945, **4,** 135.
7. MARTLAND, H. S.: Air embolism; fatal air embolism due to powder insufflators used in gynecological treatments. Am. J. Surg., 1945, **68,** 164.
8. BREYFOGLE, H. S.: Death from air embolism following insufflation during pregnancy; report of case. J. A. M. A., 1945, **129,** 342; correction, 1945, **129,** 643.
9. VANCE, B. M.: Intrauterine injection of lysol as abortifacient; report of fatal case complicated by oil embolism and lysol poisoning. Arch. Path., 1945, **40,** 395.
10. STEINER, P. E., AND LUSHBAUGH, C. C.: Maternal pulmonary embolism by amniotic fluid as cause of obstetric shock and unexpected deaths in obstetrics. J. A. M. A., 1941, **117,** 1245 and 1340.

The clinico-pathologic conferences of the Georgetown University Medical Service at Gallinger Municipal Hospital are open to any interested physician who cares to attend. Protocols for the following week's case are distributed at each exercise. Conferences will be held each Friday at 12:00 noon from October 3, 1947, to May 28, 1948, in the auditorium on the ground floor of the Medical Building at Gallinger Municipal Hospital. There will be no conferences on November 28, December 26 and March 26.

President's Page

A PLEA FOR UNITY

For one hundred years the American Medical Association has been the guiding force in medicine in this country. Its policies have been determined by a wealth of experience. Largely through its efforts, the standards of medical education and practice have risen to the highest peak ever reached in any country.

In spite of this, and because of the position it has taken on certain social and economic matters, there has been considerable criticism within and outside the Association. This criticism has resulted in the formation of several groups of physicians for the avowed purpose of either supporting or condemning its position. As a result, there has been a diversification of ideas and considerable confusion among both the profession and laity as to the true aims of American medicine.

The American Medical Association is a democratic organization. Its House of Delegates is elected by the various component state organizations. Delegates to the state bodies are in turn elected by the county organizations. While this pyramiding might seem unwieldy, it makes it possible for any group within the organization to make itself heard.

The formation of outside medical groups to support or oppose the policies of the American Medical Association can serve only to weaken medicine's hand. Far more would be accomplished if the efforts of these groups were expended within the Association. Our Society, while recognizing the right of an individual to join any organization he wishes, has taken this stand. It has never endorsed any outside group.

If the policies of the American Medical Association are sound and right they should be supported. If they are wrong or unsound they should be changed. By working within the structure of its present organization, we can be instrumental in the formation and execution of its policies. Let us stick to the channels open to us to promote strength and unification of action.

Raymond J. Holden

Editorials

"ADEQUATE DIRECTIONS FOR USE"*

The policy of *caveat emptor*, so far as drugs are concerned, has been changed to "let the physician prescribe."

The Food, Drug and Cosmetic Act of 1938 was not designed to prohibit self-medication, but to make self-medication safe. Without considering details or exceptions it might be stated that the law recognized two broad classifications of drugs in terms of labeling requirements. Until a little less than two years ago, a manufacturer could label a drug with "adequate directions for use" by one of two procedures. With certain technical exceptions this requirement of the law could be met either by (1) full dosage directions, necessary cautions, and in the case of some drugs, specific warnings against misuse, or (2) labeling with the so-called "prescription legend," "To be used only by or on the prescription of a physician, (dentist or veterinarian)," under which circumstance no directions for use were required. Theoretically, this distinction of labeling was designed for two general classes of medication: first, those products commonly called "proprietary," which are intended to be sold directly to the consumer for self-medication, and for which obviously full directions for use must be provided; and second, the so-called "ethical specialty" product, which is usually the subject of a physician's prescription, upon which he places appropriate directions to be carried over to the prescription package by the pharmacist. Preparations labeled with the "prescription legend" frequently carried abbreviated directions for use, and the label of some proprietary preparations, carrying full directions for use, often added phrases such as "or as directed by the physician." Thus the distinction between these broad groups of drugs gradually disappeared. In addition to this practice some preparations, which were actually intended for "over-the-counter" sale, were labeled only with the "prescription legend" and without any directions for use.

By law pharmacists must insure that every drug dispensed or sold over-the-counter is properly labeled. During the first seven years of operation under this law, major differences of opinion, and not a small amount of confusion, developed both within the professions and the Government. Some manufacturers, unable to ascertain precisely what the Food and Drug Administration would consider "adequate directions for use" sought refuge in the use of the "prescription legend." While the dilemma of the manufacturer can be appreciated, this practice served to compound the problem for pharmacists and physicians. Five years ago very simple preparations commonly sold over the counter on public demand were frequently labeled with the "prescription legend" and without directions for use. While the use of this legend exempted the manufacturer from the necessity of "adequate directions for use" it merely transferred the burden of proper labeling to the pharmacist. In some instances pharmacists would not attempt to label medicinal preparations because of the potential dangers of the drug. In many instances it would be apparent to the pharmacist that a physician had advised the patient to purchase the drug and the dosage to follow. Any attempt at labeling with directions by the pharmacist might well have been in conflict with the wishes and the instructions of the physician. In still other instances general directions could have been attached by the pharmacist but this would have meant destroying the appearance of the original package, a circumstance that customers would resent because they expect to obtain a product as prepared by the manufacturer.

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* This is the twentieth in a series of guest editorials by distinguished physicians and laymen.

Under an amendment to the regulations of the Food, Drug and Cosmetic Act, which became effective October 1945, drugs or preparations which are susceptible to labeling that will provide completely adequate directions for lay use, must be labeled by the manufacturer with full directions for use. Drugs and preparations which are not considered safe and efficacious for use except under the supervision of a physician, must be labeled by the manufacturer with the "prescription legend," and under this condition neither the container nor the package may carry any directions for administration or statement of conditions for which the drug may be used. Such drugs may be sold only upon the prescription of a physician.

Thus a condition has arisen in which many drugs, frequently recommended by physicians to their patients for direct purchase without a prescription, are now required to be labeled by the manufacturer with the legend, "To be used only by or on the prescription of a physician." To illustrate, all earache drops and ophthalmic ointments, many of which formerly carried directions for use, now are labeled, "To be used only by or on the prescription of a physician" and, accordingly, can be supplied by pharmacists only on prescription. Barbiturates and the "sulfa drugs" are also restricted to prescription use. These random but clear-cut examples should serve to point up the changing order and the adjustments of past practice which must be made by medicine, pharmacy and the public. The real interprofessional and public relations problem is concerned with the vast number of borderline preparations which can now be obtained only upon prescription but which in the past were labeled with directions for use and were available without prescription. Customers in the past may have purchased a given drug labeled with directions for use, and cannot understand why the pharmacist now refuses to sell the same preparation, which now bears the "prescription legend." Patients assume that physicians instructing them to make direct purchase from a pharmacy believe that the product can be purchased without a prescription, and, accordingly, blame the pharmacist for delays in supplying the needed medication. If the pharmacist assumes such preparation was ordered by the physician and sells it to the customer with the original manufacturer's label bearing the legend, "To be used only by or on the prescription of a physician" he is guilty of violation of the Food, Drug and Cosmetic Act, and subject to severe penalties. If he does not supply the preparation requested he offends the patient, delays the treatment, and burdens the physician with a return visit of the patient to obtain the necessary prescription.

The new regulations, while temporarily disturbing to physicians, pharmacists and the public, are probably sound and ultimately will prove beneficial to all. Much misinformation and misunderstanding, as well as suffering, have resulted from failure to understand and apply the regulations properly. The moral, legal and professional responsibility of medicine and pharmacy is clear and must be met through public education and interprofessional coöperation. For the common good, the public must be properly and fully informed on this matter by the professions acting jointly. This is one of many problems in which the Interprofessional Conference hopes to be of service to the professions and the people of Washington.

The District of Columbia Pharmaceutical Association, with the advice of the Federal Food and Drug Administration, is currently developing an announcement which it is hoped will establish a firm guideline for pharmacists as to drugs which may be sold "over-the-counter" and those which must be restricted to prescription use only. When this task is completed it is imperative that physicians and dentists familiarize themselves with the controlling facts and govern their prescribing and instructions to patients accordingly. Of equal importance is the matter of informing patients of the legal necessity of prescribing controlled drugs, especially when many such drugs previously could be obtained on the verbal request of the patient.

In summary, and without consideration of technical exceptions, all members of the professions of medicine and pharmacy must understand that it is a violation of federal law to sell, except on prescription, any drug preparation that does not bear adequate directions for use, and that adequate directions for use can be carried only on preparations which are considered safe and efficacious for use without medical advice. Prescriptions should be written for all medication unless the physician is certain that the desired drug is properly labeled as an "over-the-counter" product. In this manner physicians may better control the medication of their patients, avoid delays in delivery, spare themselves annoyance, and relieve pharmacists of embarrassment. It is recognized that all must adjust themselves to a wholly new concept of physician-patient-pharmacist relationship in the handling of drugs. By the coöperative effort of all three elements in this vital public health triangle, the professions will enjoy greater peace of mind, and the welfare of patients will be protected. Until more definitive information can be prepared and distributed, it is suggested that when in doubt about the legality of the sale of any drug—"Let the physician prescribe."

W. Paul Briggs, B.S., M.S., Sc.D.
President, Interprofessional Conference of the District of Columbia

PSYCHOPATHIC DIVISION OF GALLINGER HOSPITAL

In perusing local newspaper accounts of matters psychiatric over a period of several years it is significant to note the shifting trend of interest in psychiatric reforms from time to time. Three or four years ago this emphasis was directed toward the improvement and expansion of psychiatric facilities at Gallinger Municipal Hospital. An investigating commission was appointed; it made a survey and recommended appropriate changes and improvements. Up to this point the recommendations have been ignored. Who is responsible for this neglect and what can be done about it?

In the last two years the emphasis shifted to the problems of the alcoholics and their rehabilitation by psychiatry. Through the efforts of Mr. Hebert, member of Congress from Louisiana, arrangements for the establishment of a clinic for the treatment of alcoholics are being consummated.

Within recent months, after a particularly severe wave of "sex crimes," the spotlight of interest has shifted to this latest problem. As a result there have appeared many comments in the newspapers, forums on the radio, and other types of publicity.

Where will the focus shift to next? No one knows, of course, but undoubtedly it will change. Something is being done about alcoholics, about sex crimes, etc., but there always remains the basic problem of deplorable conditions in the Psychopathic Division at Gallinger Hospital. It is a well-known and monotonously repeated fact that the Division is woefully understaffed at all levels. There are not nearly enough doctors to handle the volume of work on such an acute service with such a large turnover of patients. Because of the sheer pressure of writing histories and performing similar basic tasks there is no opportunity at all for treatment, very little time for adequate observation of patients, none for research and teaching. Patients presenting even minimum problems of treatment and handling are hurriedly transferred to St. Elizabeths Hospital as emergencies even though the only difficulty may be that the patient is disturbed. Why are physicians not attracted to work at Gallinger? And why do they not remain after accepting positions? For a number of years Dr. Isaac Silverman carried on excellent work in the treatment of acute alcoholism by using intravenous injections of hypertonic salt solution. Since his death we are not aware of any other published work from the Psychopathic Division at Gallinger.

At another level is the shortage of nurses and attendants. There are never enough of either to handle the volume of patients. It is not a rare experience for visiting physicians to find patients locked in one of the wards with no attendant or nurse in the ward with the patients. Patients in these wards are victims of many conditions; they may be disturbed, suicidal, acutely alcoholic, hallucinated, etc. Left unattended there might be serious consequences if one of the patients suddenly experienced an aggravation of his condition, or attacked another patient. Occasionally the visiting physician finds himself locked in the ward and is unable for some period of time to leave when he has finished his business because he is unable to attract the attention of someone outside the ward who has a key. When this matter was brought to official attention promises were made to furnish more help, and appropriate allocations were made. However, it is rumored that this help has eventually been diverted to the main building, another evidence of psychiatry being regarded as a stepchild. Modern mental hospitals employ almost no mechanical restraints for disturbed patients. At Gallinger the shortage of attendants requires a maximum exhibition of such restraint, a condition which in itself is a great handicap to the patient's eventual recovery. A disturbed patient is manacled hand and foot to his bed. The shortage of attendants requires that members of the Metropolitan Police Force be detailed to the Psychopathic Division.

A visitor entering the Administration Building experiences great difficulty in obtaining information about patients, guidance in finding the doctors, etc., because no one is assigned to this duty. This important deficiency was brought to the attention of the Red Cross two years ago, and this agency offered to furnish Gray Ladies who would greet visitors, direct them to doctors and patients and, in general, function as receptionists and sources of information. This offer was rejected on the grounds that the good ladies might be subjected to unpleasant experiences! As a result visitors continue to blunder around looking for doctors, seeking information and directions.

At Gallinger the Pediatrics Division occupies quarters on the second floor of the Administration Building of the Psychopathic Division, within a stone's throw of the three buildings housing the psychiatric patients. What reasonable excuse can be offered for housing children in such surroundings, where the cries and obscene shouts of the psychiatric patients are easily heard?

The facilities in the Divisions of Medicine, Surgery, Obstetrics, etc., are used extensively by the students of the George Washington and Georgetown University Schools of Medicine. These Divisions are adequately staffed by teachers assigned from the faculties of these two schools. Patients are thoroughly examined, teaching and research encouraged. The medical schools do not assign their students and teachers to the Psychopathic Division. There must be a good reason for such a different policy. One of the schools has refused to allow its students access to the Psychopathic Division because of the bad practices they would observe there.

As in all mental hospitals, the social worker plays an important role in such functions as interviewing patients' relatives and friends, obtaining essential information, arranging for the patient's discharge from the hospital, and his reception at home. At Gallinger one overburdened social worker tries to cope with an average daily census of 140 patients. During the period from January 1 to July 1, 1947, there were 1,950 admissions. It is evident that one worker can hardly do the essential work at the Hospital; absolutely necessary visits to the patients' homes are impossible.

Under present arrangements Gallinger functions only as an observation ward, separating nonpsychotics from psychotics and transferring the latter group to St. Elizabeths Hospital. All authorities today agree that the emphasis in psychiatry should be on prophylaxis, teaching, and active treatment given early. Similar campaigns have been successful in the fields of tuberculosis, heart disease, and cancer. The American Hospital Association recommends that 15 per cent of all beds in new general hospitals be planned for the care of neuropsychiatric problems. A number of general hospitals throughout this country have added neuropsychiatric facilities and discovered the addition to be of inestimable value to the patients, the hospital, the staff, and the community. At Gallinger we find not only an absence of facilities for prophylaxis, teaching, and treatment, but even a lack of adequate care for those actively psychotic. Early in September it was announced that an Outpatient Psychiatric Clinic will open soon at St. Elizabeths Hospital. As an agency of the District of Columbia should not Gallinger provide such facilities for the residents of Washington? Within the District of Columbia there are no special facilities for the treatment of the mentally ill, aside from those at Gallinger. There are no other psychiatric hospitals, and none of the general hospitals provide such care. Facilities at Gallinger should be expanded and developed in order that such care can be developed. Such a move might serve as a model and incentive to the other general hospitals.

What should be done about this serious problem which affects a fairly large percentage of our population? The Medical Society should take the lead in a vigorous campaign to improve conditions. An actively functioning committee should investigate existing conditions and then pursue the proper authorities for improvement. This pursuit should start with the Superintendent of the Hospital, then to the Health Officer, to the Commissioners, and, finally, to Congress. Without doubt one of the important causes of present deficiencies is the lack of money for improving present buildings, erecting new buildings, and increasing salaries to levels which will attract more personnel. The sources of moneys must be informed of the problem by physicians interested in the welfare of sick people. When conditions are improved medical students and their teachers will work in the wards. In addition, the increased prestige of the Psychopathic Division would attract auxiliary groups of necessary professionals and volunteers, such as social workers, occupational therapists, nurses' aides, etc. There is good precedent for this suggested campaign. For a number of years the late Dr. William A. White led a vigorous and successful campaign of the Medical Society to revise the antiquated and inhumane laws relating to the commitment of persons to Gallinger and St. Elizabeths Hospitals. These efforts culminated in the enactment of the present modern laws governing commitment procedures.

Isadore Rodis, M.D.

DIABETIC CAMPS

Twenty-five years ago camps for diabetics were unknown. Today hundreds of juvenile diabetics are able to enjoy the same benefits afforded their nondiabetic young friends at summer camps, which previously were unobtainable because the special care required by the diabetic child was unavailable at such places. This year there were at least 13 camps operating in various parts of the country sponsored by medical and other organizations. At such camps physicians and nurses skilled in the care of the juvenile diabetic, aided by dietitians, laboratory technicians and recreational directors, make camp life safer than home life for most of the participants.

Washington was one of the first cities to have a diabetic camp, through the coöperation of the Christ Child Society which placed their Convalescent Farm at Rockville, Maryland, at the disposal of the diabetic children of Washington. The first camp was held there in 1937 and was continued annually. The camp was interrupted by the War, but was reactivated this summer as the sixth camp to be held. Six diabetic children lived and played very much as did 26 nondiabetic children, except for eating a weighed diet, taking insulin, and submitting to certain laboratory examinations. The casual observer could distinguish no difference between the two groups. This is as it is intended to be, for the purposes of the diabetic camp are to make available a safe summer outing for the diabetic child and to bring him in contact and competition with the nondiabetic child of his own age, with the idea of establishing in the former's mind the realization that there are no great differences between himself and his fellows. The benefits and joys of living are there for the diabetic to enjoy if he is willing to "play the game." A recent article in this journal by Benjamin[1] stressed the mental hazards which beset the adolescent diabetic. Proper mental and physical care given diabetic children at camp aid in making these future adult diabetics normal thinkers as well as healthy individuals.

The Washington Diabetic Camp this year was the first project to be sponsored by the recently organized Diabetes Association of the District of Columbia.

E. C. R.

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[1] Benjamin, S.: M. Ann. District of Columbia, 1947, **16,** 361.

MEDICINE AND THE SEX OFFENDER

Recently attention has been called by the public press, particularly by the *Washington Star*, to the fact that the criminal laws of the District of Columbia are extraordinarily weak and ineffective in their provisions relating to the perverted sex offender and the sexual molester of children. As a result, the police, the prosecutors, and the courts are well nigh helpless to protect the public adequately in this field of criminal activity.

Offenses of the types referred to, as well as the well recognized crime of rape, stir a community as do few varieties of anti-social conduct, and it seems highly probable that the seriousness of the former group will be recognized by the establishment of higher penalties in the form of longer potential periods of confinement. However, just as alcoholism is now coming to be generally recognized as a disease rather than a crime, so is there a wide realization that certain types of perverted sex conduct are so far from ordinarily accepted standards as to be clearly pathological.

The work of the psychoanalytic school has shed much light on the mental mechanisms of this sort of behavior, so that it is now well understood by the psychiatrist. Furthermore, some of the offenders may, if they will accept treatment, be helped. Four states (California, Illinois, Michigan and Minnesota) have already enacted laws, now in effect for nearly a decade, and all sustained as constitutional, defining a type of mental disorder short of "insanity" which they denominate "criminal sexual psychopathy," or by some similar name (the laws are, of course, not identical). This condition is not a defense to the charge of crime; if it exists, however, it permits commitment to a special institution. If the defendant is found to fall in this category, he is given an opportunity for psychiatric treatment, and if he responds, he is then returned to stand trial or be otherwise disposed of by the prosecutor; if he does not respond, society is protected by his prolonged detention, just as if he were found to be "insane."

Congressman George MacKinnon of Minnesota introduced such a bill in the last session, but it was not reached for action although a hearing was held. United States District Attorney George Morris Fay is now studying the whole problem, with the assistance of physicians and a committee of the Bar Association. It may be hoped that in any bill designed to protect society from the depredations of this class of offender, recognition will be given to the fact that a measurable proportion of the defendants are mentally abnormal, and that in their case special measures should be provided to cure the defendant if possible, and if not, to prevent repetition by safe confinement while repetition is likely.

Such a step will be at the same time sound medicine, sound public administration, and sound insurance for society.

W. O.

In and Out of Focus

BY THE OBSERVER

Another Study of Physicians

Elsewhere in this issue of the Medical Annals, there appears an article by Antonio Ciocco and Isidore Altman, Division of Public Health Methods, U. S. Public Health Service, entitled "The Postwar Survey of Physicians Practicing in Washington." This article contains a report on the study recently completed by the U. S. Public Health Service at the request of the Medical Society of the District of Columbia.

Officials of the Society were quite certain that the survey would show that the District and its environs were amply supplied with physicians. In fact, because of the great influx of practitioners following V-J Day, they would not have been surprised if there had been a surplus. However, the surveyors found that while there has been a great increase in the number of physicians, there has been a comparable growth in the population of the Washington metropolitan area. As a result, the ratio of physicians to population is approximately the same as it was before the War. This was indeed a surprise, but a pleasant one.

As might have been expected, the patient load had fallen by some 40 per cent since the last study was made of physicians in the metropolitan area in April, 1945. The greatest decrease was among the general practitioners and internists, which perhaps is not too surprising, as they constitute the largest number of practitioners.

The question which still remains unanswered is whether the metropolitan area could assimilate more physicians. Your Observer looked for that answer in the report, but it wasn't there. The reason, the surveyors said, is that there is no basis for determining the proper ratio of physicians to population. Dr. Ciocco pointed out that no one has yet defined adequate medical care. Until this is done, the number of physicians needed for a given population cannot be definitely ascertained. At the present time those who seek the answer to this question must be satisfied to base their conclusions on the demand for the services of physicians.

Of course, when comparisons are made between such jurisdictions as the District of Columbia and Mississippi, it is obvious that the latter needs physicians more than the District. There simply are not enough practitioners to render the most essential services.

All of which leads to the conclusion that studies should be undertaken immediately to determine what constitutes adequate medical care. There will be little scientific basis for statements made with respect to the number of physicians required until this has been ascertained.

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A Novelist at the AMA Convention

Doctors will not particularly enjoy the manner in which the novelist, Bernard DeVoto, pictures them at last summer's Atlantic City Convention. In an article entitled "Doctors Along the Boardwalk" appearing in the September, 1947 number of *Harper's*, DeVoto has praise but also hard words for doctors. He is especially bitter when he takes the AMA leaders to task for their opposition to compulsory health insurance.

What are DeVoto's qualifications for his self-appointed task of appraising doctors? The Editor of *Harper's* assures readers that DeVoto is "naturally fitted to observe at the recent Atlantic City Convention, since his latest novel 'Mountain Time' deals with the life of a surgeon." This rather naïve statement would be amusing were it not for the fact that, judging by his article, DeVoto has acquired considerable knowledge of medical matters.

How did the physicians at Atlantic City impress DeVoto? He says:

> "If there was anything that distinguished them from any other crowd, it was that they looked a little more unhealthy than most. There were rather more men than one might have expected to see who were overweight and putting strains on their hearts that a physician would have cautioned them against, rather more men who looked underweight and harried, whom a physician would have suspected of gastric ulcers. Too many of them had not been getting any exercise; too many worked too hard and lacked the relaxation of hobbies and extra-professional interests; the incidence of hypertension was probably high.
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> "Otherwise they were any Atlantic City crowd. . . ."

He then takes the reader on a tour of the AMA Convention. His description of the Technical Exhibit is uncomfortably accurate. He sums up his observations of the Exhibit by referring to it as a "county fair." However, he says that the Scientific Exhibit puts the medical profession "in the light that we and the doctors themselves most like to see it in," and that "they [the exhibits] signalized one of the heartening realities of life, the steady advance of medical science."

> ". . . The convention exhibits and the discussions in the general and section meetings," he continues, "are an admirable way (less valuable, naturally, than refresher courses) of keeping in touch with what the researchers have been finding out. They are the chief professional reason why doctors attend the AMA conventions; of the sixteen thousand at Atlantic City, a majority may be assumed to have come from small towns, or at any rate from places that are remote from a medical center."

Summing up his views on the scientific aspects of the meeting, DeVoto says:

> "Here, one repeats, is where the medical profession looks best—looks better than most groups of men, looks almost as good as the messianic or megalomaniac rhetoric of its orators makes out. Here it shows the attributes that have enabled medicine as a science steadily to push the frontier of knowledge farther into the area once marked unknown, and have kept medicine as an art of human relations a constant solace to men in pain, fear, and sorrow. Patience, ingenuity, courage, skepticism, faith, the experimental spirit, the open mind, readiness to

test innovation, laborious and exhaustive analysis of data, a constant quest for new data—such things as these have steadily carried medical knowledge onward to repeated victories, repeated subjugation of diseases that seemed impossible to subjugate, repeated solutions of problems that seemed insoluble. The mind of the medical researcher is the human intelligence at its greatest, and the total personality of the good doctor dealing with a patient is human skill and wisdom fused inspiringly. Moreover, the profession as a whole shows an eagerness for greater knowledge and greater skill that no other art or profession quite equals.

"Such realizations are forced on you when you see sixteen thousand medical men gathered in professional consultation. . . ."

At about this point, DeVoto's praise for the medical profession ends. He is especially severe on the AMA for its position on sociologic and economic matters pertaining to medicine.

> "Systematically and tirelessly, with all the means available to one of the most powerful pressure groups and propaganda machines in the country," he writes, "the AMA has opposed every measure in which it detected any connection whatever with what is surely coming. It has done so sometimes suavely, sometimes with amazing crudity, sometimes by individual pressure the most dishonorable, sometimes by flagrant mass appeals the most mendacious. . . ."

He accuses the AMA and the "hierarchy" of state and county societies which support it of having been violently reactionary. He says that under pressure a change in attitude has slowly come about within organized medicine. He charges the AMA with opposing compulsory health insurance because it "insists on complete unsupervised control of any program that may evolve, and it requires that plan to interfere with the fee for service system as little as possible, not at all wherever there is any way to maintain the system." He says this is so unrealistic it "suggests the need of psychiatric scrutiny."

> ". . . Again, nothing is surer than that the evolution of health insurance and the like will provide not one health program but a good many—as many systems of medical practice, say, as there are systems of banking, from wholly private to wholly public—but the machine must continue to grind out the propaganda which the *Journal* has been purveying for nearly twenty years: that the reds are forcing on us a single all-or-nothing, either-or, black-or-white choice between freedom and slavery. Again, throughout medicine and even in the AMA, there is much rejection of, and rebellion against, the official attitude toward what the propaganda insists on calling 'state' or 'socialized' medicine—but at all costs organized medicine must publicly appear to accept as inspired truth the party line of the Trustees, the House of Delegates, and the bureaucracy."

There is much more of the same but these excerpts make it clear that DeVoto is less sympathetic to organized medicine's views on methods of supplying medical care than to its achievement in the purely scientific field. His article may win few medical friends, but physicians who read his article objectively will conclude that, on the whole, DeVoto has done some pretty straight thinking.

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". . . a Thoughtless Ignoramus . . ."

Nearly every physician who serves a medical society in an official capacity has his unhappy moments. These may occur infrequently but when they do they can be upsetting. Among those who cause him distress are members who take a "holier-than-thou" attitude toward what they refer to disdainfully as "medical politicians." Few have delivered themselves as feelingly in regard to these critics as the Editor of *Northwest Medicine*, who writes in the August, 1947 number of that journal:

> "The man who sanctimoniously sneers at some of his fellows by referring to some of them as medical politicians should try some time to find out just what the term means. Unfortunately, he is usually the kind so well satisfied with his own importance to the world and so certain of his profound medical wisdom that attempts to educate him are largely useless. With his mind firmly fixed on his hospital connections, his appointment book and the state of his bank account, he is serenely oblivious to the problems of our public relations and the various legislative attacks upon the profession. Yet, in tones of derision he will refer to those who unselfishly study such matters as medical politicians. . . ."

Branding the physician who uses such a term as "a thoughtless ignoramus" he continues:

> "State medical associations and the American Medical Association place supreme authority in the hands of the House of Delegates. Annual or semi-annual meetings of these bodies are open, almost invariably, to anyone who wishes to attend. But whom do you find there? Not the sanctimonious one. Oh, no. It is the medical politician who spends his own valuable time and who devotes much careful thought to the serious matters confronting the association. The House of Delegates may hammer out, on the anvil of public debate, a decision for action by the State Association which will profoundly affect the practice of medicine for years to come. But where is the critic of the medical politicians? Probably out fishing or playing golf. Certainly he is not lending his talent to the good of his fellowmen.
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> "Most state associations have a Council or a Board of Trustees which meets at intervals throughout the year to act for the House of Delegates between its sessions. Members of these groups, must, perforce, drop their affairs, miss cherished time at the home fireside and travel to the meeting place to wrestle with problems which concern us all. These are the medical politicians, these board members who would rather be showing junior how to cast a fly or be taking the whole family for a Sunday drive, but who are unselfish enough to give of themselves for the good of others.
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> "The American Medical Association has many Councils. They have accomplished much in the fields of education, pharmacology, hospital standardization, public relations and medical service as well as in judicial matters concerning the Association itself. Who are the men who devote their precious time to these activities year after year? No one will do it but the medical politicians. The critic? No, of course not. He has not time to bother with such things. He is just too busy with his practice, so important. But the status of his very livelihood is profoundly dependent upon what these councils do. His fine position can be ruined very readily at any time, if he and others like him continue to ignore the major problems of the whole profession.
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> "Times are perilous, indeed. The medical profession is confronted with problems such as it has never faced before. If certain trends now apparent are not soon reversed, the whole system of private practice of medicine is apt to disappear from the American scene. They can be reversed only if the entire profession is willing to sacrifice and work to reverse them. The medical politicians have struggled sincerely to avert the danger. Now it is necessary for all to help. If you want to learn the facts, ask the man who knows and can tell you, the medical politician."

Your Observer would be the last to disagree with the general premise of the distinguished editor. There are medical society officials who, having made real sacrifices for their organizations, have been returned to obscurity without a word of thanks. Too many also have been hurt by the criticism of those who contribute nothing.

On the other hand, not all medical leaders fall in this category. There are those in medicine, as in every other field, who contribute very little to the welfare of the groups which honor them. They accept prestige and power with no sense of obligation.

By and large, most medical society officials, being human, are selfish to the degree that they enjoy the honors that come to them. Aware of the responsibilities which go with the offices they hold, they also do something to earn the recognition which they receive. Such officials are in the majority and deserve the support and respect which is usually shown them.

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Every Doctor a Psychiatrist

Readers of this column will recall Dr. C. Charles Burlingame's warning that the 4,000 psychiatrists in this country cannot possibly cope with the demands now being made upon them, and that "unless this dangerous preoccupation with negative psychiatric matters is quelled, thousands of people seeking psychiatric assistance will be unable to have their conditions medically evaluated, and many who are delicately balanced will resort to the questionable succor of charlatans."

In addressing the annual meeting of the Kansas Medical Society last May, Dr. Karl Menninger supported this view, reiterating Dr. Burlingame's warning. However, he urged, "We must bend every effort to increase the number of properly trained psychiatrists with which we are so shockingly undersupplied."

But Dr. Menninger would go far beyond that.

". . . In view of the fact that all statistics indicate that half of all the patients seen by all the doctors in all the cities and towns and country are non-organic cases, cases more psychiatric than surgical, it is perfectly clear that we are never going to have enough psychiatrists. Every physician except those who specialize in some limited technics is going to have to be his own psychiatrist to a very considerable extent. According to his interest, his conscientiousness and his ability, he is going to do this well or he is going to do it poorly, but he is going to have to do it, and the time will come when for a doctor to blunder in the psychiatric management of a patient will be considered just as reprehensible as to blunder in the surgical management of a patient."

Dr. Menninger believes that in part the increase in psychiatric patients is due to the pressure to which people in our day are subjected. Of equal and perhaps more importance are what he calls changes in our scientific conceptions. "In plain English," he explains, "this means that we now relate illness to the patient's total personality, and view any particular illness as a derangement, not of the patient's body chemistry or body physics or psychology alone, but of all three."

He enlarges upon this thesis and then concludes, "I may seem to be advocating the disappearance of the psychiatrist. I do so because I conceive of psychiatry as belonging within the framework of medicine as a whole. Medical psychiatry and psychiatric medicine are one and indivisible and embody the essence of sound diagnostic and therapeutic practice."

★

Does It Pay?

Physicians have been heard to remark that there is no purpose in increasing their incomes because the Government takes it away from them in taxes anyway. Perhaps one shouldn't take these statements too seriously. On the chance, however, that some physicians might be serious about it, a few observations would seem to be in order.

In the July, 1947 number of the *Delaware State Medical Journal*, there appeared an item by Wilfred I. King, Ph.D., Professor Emeritus of Economics of New York University, entitled "Does It Pay to Work Harder?" In the course of his comments on this subject, Dr. King said:

> "For the man who earns $4,000 above his exemption, it manifestly pays to work harder and earn $2,000 more, for Uncle Sam lets him keep three dollars out of every additional four that he gains by his hustling. The man making $8,000 above his exemption will probably feel it worth while to add $2,000 to his income, for he is still privileged to keep two out of every three added dollars. However, for the man having an income of $15,000 above his exemptions, the worthwhileness of striving to take in another $5,000 raises serious questions in his mind, for, in his case, the Federal Government takes more than half of the added gains. One can hardly expect the man receiving $100,000 to be much interested in doubling his income, for, if he does, he can only keep for his own use one dollar out of every additional seven.
>
> "Obviously, the present income tax law constitutes an effective device for preventing the most efficient business and professional men from fully utilizing their talents. The law acts, therefore, as a damper on production, and hence lowers the income of the average citizen."

While the average doctor naturally endeavors to make an adequate living, he is no more concerned with the effect of taxes on his income where his patients are concerned than if such taxes didn't exist. And that isn't just sentimental drivel. It is true.

Of course, there are commercially-minded doctors and even some others who wish to give the impression that they are hard-headed business men. Even they cannot escape the feeling that they must fulfill their responsibilities as physicians regardless of financial considerations.

There may be a few physicians who are prevented by present tax laws from "fully utilizing their talents" but your Observer believes them to be a very small group.

Unknown Factors in Medical Costs

There is a staggering volume of data on the subject of medical costs. Innumerable studies have been made by Government agencies, medical organizations, foundations, insurance companies and others. Recently, the Bureau of Research and Statistics of the Social Security Administration issued what it called a statistical source book, "Medical Care and Costs in Relation to Family Income." This book contains a vast amount of statistical data, some of it new, much of it old.

In an effort to ascertain costs to hospitalized patients, your Observer examined this book and much other material; however, he failed to discover the data sought. He also directed inquiries to those who should be able to supply the information but received a negative response. He was told no such studies as he had in mind had been made.

It is generally agreed that patients, except for those in the lowest income brackets, can pay ordinary medical costs. Costs become difficult for them to cope with only when hospitalization for serious illness is necessary. Charges for refinements in medical service multiply rapidly upon entering the hospital. There are the X-ray and various laboratory tests, drugs, nursing, anesthesia, operating room, and the patient's room plus physicians' services.

With respect to the latter, it should be pointed out that patients are usually not too concerned with physicians' fees. What troubles them is the over-all cost of their illness.

A hypothetical case might suffice to indicate how serious costs of illness may become for a patient of moderate income. Mr. J., who has an income of $3,000 annually, becomes seriously ill and, being in need of an operation, is placed in a hospital. A modest hospital room costs him $12 a day. Because the condition for which he is to be operated is serious, three or four special nurses are required the first few days. Blood tests and perhaps X-ray plates are also essential before the operation. The charge for the use of the operating room proves to be a major item. Then, of course, there is the surgical operation itself. At even modest fees, the total cost of hospitalization and professional services exceeds $700, which, at his income, is a severe hardship, if not catastrophic.

It seems to your Observer that the time has come when the facts with regard to the costs to hospitalized patients as compared with their income should be ascertained. They would undoubtedly prove very revealing and perhaps point the way to some solution for the patient.

The Medical Society would have little difficulty in obtaining the necessary assistance to make such a study in the District of Columbia. In your Observer's opinion, it should take the initiative and do so promptly.

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Physicians Support Medical Service

Members of the Society have long since received their contracts to participate in MEDICAL SERVICE OF THE DISTRICT OF COLUMBIA and such enclosures as a description of the plan, a schedule of fees, and the Subscriber's Certificate. In excess of 500 physicians had returned signed contracts when this was written. More important than the number who responded is the fact that general practice and the various specialties are well represented. There is no longer any doubt that District physicians will support the Society's prepayment plan and do all in their power to make it successful. At least another 200 are expected to sign their contracts before these lines appear.

Dr. Frank D. Costenbader, President of the SERVICE, in his initial communication, urged all members of the Society, whether or not their services would be required under the plan, to return the agreement sent them. He gave as his reason the fact that when the plan is expanded to include other services, another canvass will be unnecessary.

(*Continued on page 594*)

SHIBBOLETH IS AN OLD WORD

Harvey T. Sethman

Managing Editor, Rocky Mountain Medical Journal

Editor's Note: The *Rocky Mountain Medical Journal* is the official publication of the Colorado, New Mexico, Utah and Wyoming state medical societies, the Colorado Hospital Association, and the Rocky Mountain Medical Conference. A progressive, well edited journal, it reflects the ability of its editorial staff.

Mr. Sethman, the author of this article, is not only held in high esteem as a medical society executive but as an able editor whose newspaper experience has especially qualified him for his editorial duties.

Medical societies, local, state and national—even the revered American Medical Association, have recently "discovered" that they have public relations problems and must really do something about it. A medical public relations program is a new shibboleth that opens important doors, but doors that medical societies sometimes slam shut again if the word is mispronounced.

The "discovery" was forced upon most medical societies from without. They had failed to listen to prophets within. It would be wise for them to remember that shibboleth is an old, old word and that there is really nothing new about public relations either.

A glance through back files of the *Rocky Mountain Medical Journal* shows that the subject was dealt with admirably a quarter of a century ago. There is a distinctly modern ring to an analysis and recommendations on public relations contained in the presidential address given in 1923 before the Denver County Medical Society, for instance. The minutes of many societies and the pages of journals long forgotten contain similar presentations.

Why then wait twenty-odd years for action? What just now awakens the medical profession? It is simply that increasing pressure and warlike attacks on the whole profession from without its membership have made physicians realize that, as a group, they must regain admittedly lost public support if they are to continue to practice medicine in a climate of traditional American freedom. And public support results from good public relations.

It seems that a majority of physicians still think of a public relations program in terms of press agents, four-color magazine advertisements, and equally flamboyant radio programs, high-pressure salesmanship, high-priced so-called contact men, and legislative lobbies.

But this is not the modern conception of a public relations program for a medical society. Rather, modern medical public relations programs should begin with competent service to the patient and to the public in the traditional manner which the medical profession has always followed, plus an individual, county society, and state society sense of public responsibility, whereby each member of organized medicine thinks of his daily activities in terms of their relationship to the whole people. Putting it another way, the medical society should be the doctor to the community it serves just as the physician is doctor to his patient.

In the complicated social structure in which we live today, that sense of public responsibility should gain expression through the committees and official bodies of the medical society. The individual physician must conduct himself in a manner to reflect credit upon his whole profession, but the medical society should represent him in similar conduct toward the community. Too long have medical societies abandoned to non-medical groups the task of awakening public interest in and awareness of the major threats to human health and welfare.

Medical societies have left health leadership to tuberculosis associations, to public health leagues and councils, to cancer societies, heart associations, civic groups, parent-teacher associations—the list has no end. Thus too often the non-medical group has received all the public credit for reducing death or morbidity rates, while in fact members of the medical profession provided the research, the know-how, and the man-hours of scientific diagnosis and treatment that accomplished the results. This happened simply because the lay groups understood and used time-proved technics of public relations, while medical societies stood on the side lines and approved where they should have been the leaders.

A public relations program for a state or county medical society involves demonstration to the public, by action on the part of the organization, that the medical profession is aggressively on the alert in protecting the health of the people. Medical society committees study the facts, identify the health hazards, draw up a plan of action, and then enlist the aid, not the leadership, of non-medical civic groups in doing something about the situation. This is what expert counselors call enlightened public conduct, and through such a public relations program—when it is properly publicized—the public grows to look to the medical profession for leadership in all issues of health and medical service.

There is nothing particularly new or novel about any of this. The old-style country doctor practiced it, years ago. He demonstrated not just to his patients but to his whole community that he knew his facts and that he was using his knowledge aggressively for the benefit of that community. He was regarded as the unquestioned authority in all matters of public health as well as individual health. He was a leader and the people followed his leadership. He enjoyed public relations that have known no peer.

But ways of life have changed. All the factors of modern living have become complex. So has the practice of medicine. What the old country doctor could do in his simply organized community will not suffice in our complicated society. Associations of doctors must meet this modern challenge. Fortunately, organized medicine is awakening to the plain fact that it must be country doctor to its country if freedom of practice is to survive.

And is even this new? The Principles of Medical Ethics are not new, and Section 1 of Chapter I begins: "A profession has for its prime object the service it can render humanity. . . ."

THE LAY SOCIETY FOR DIABETICS

The Lay Society is a subdivision of the Diabetes Association of the District of Columbia, Inc., and is now complete in its organization. In mid-September a drive was begun for membership. All diabetics, relatives of diabetics, and other laymen interested in the subject of diabetes are eligible for membership. Every physician in the Medical Society should urge his patients to join this group.

The objective of this Society is to carry on activities for and in the interest of the diabetic. Programs and demonstrations setting forth the problems of the diabetic will be arranged. At these meetings the diabetic will have an opportunity to discuss his individual problems and ask questions, and meet with fellow diabetics for mutual assistance. It is a society for the diabetic, to be run by the diabetic with the guidance of those expert in the management of his condition.

It is hoped that the Medical Society's membership will assist by seeing that their patients take advantage of this opportunity and join the Lay Society for diabetics. It is desirable that the diabetic be informed of this Society through his own personal physician. Application blanks in the form of a folder, which includes a letter to the patient, an explanation of the Society, and an application blank, may be obtained by the physician on request to the Society's office at 1720 Connecticut Avenue, N.W., telephone North 5034.

The opening meeting is planned for the afternoon of November 19, at which time the Lay Society will be addressed by Dr. Elliott P. Joslin of the Deaconess Hospital, Boston, who is the outstanding clinician in the subject in this country, and Dr. Charles H. Best, co-discoverer of insulin with Banting. The exact time and meeting place have not as yet been set, but the date is definite. See that your diabetics attend. Ample notice of time and place will be given later.

Will you urge your diabetics to join?

John A. Reed, M.D.
President, Diabetes Association of the District of Columbia, Inc.

A POSTWAR SURVEY OF PHYSICIANS PRACTICING IN WASHINGTON

Antonio Ciocco and Isidore Altman

Division of Public Health Methods, United States Public Health Service

Three surveys of practicing physicians were made during the War by the Medical Society of the District of Columbia with the coöperation and assistance of the Medico-Chirurgical Society, the Procurement and Assignment Service of the War Manpower Commission, and the U. S. Public Health Service.[1,2,3] The present survey, the fourth in the series, seeks the same information as those which preceded it; namely, a complete count of the active private practitioners in the District of Columbia and an estimate of their patient load. The last of the previous surveys was made in April 1945, at a time when the supply of physicians in the community was at its lowest. Since then many physicians are known to have returned from military service, and many new physicians have located their practices here. The present survey attempts to measure the magnitude of the change, with particular reference to its effect on the volume of work now done by physicians in comparison to the war years.

The data on the number of active practitioners have been derived from sources described in the earlier reports, chief reliance being placed on the list of licensed practitioners and the files of the District of Columbia Procurement and Assignment Service, the Medical Society of the District of Columbia, and the Medico-Chirurgical Society. Information about the patient load of the physicians—the number of patients seen in one week—was obtained by mailed questionnaire.

Number of Active Private Practitioners

There were on June 1, 1947, 1,324 physicians in practice in the District of Columbia. Their composition by age, sex, color and type of practice is shown in table 1. As in previous surveys this number includes a good many physicians who devote a substantial portion of their time to hospital, clinic, and teaching activities but who still carry on an active private practice. It does not include those physicians employed on a full-time basis by governmental agencies who see occasional patients in the evening.

TABLE 1

Age and Specialty of Physicians in Private Practice in Washington, D. C., June 1, 1947

TYPE OF PRACTICE	TOTAL	WHITE MALES					NEGRO MALES			FEMALES		
		All	Under 35	35–44	45–64	65 and over	All	Under 45	45 and over	All	Under 45	45 and over
All Practitioners	1,324	1,076	149	433	395	99	190	78	112	58	34	24
General Practitioners	470	312	36	126	106	44	135	50	85	23	11	12
Specialists	854	764	113	307	289	55	55	28	27	35	23	12
Internal medicine	217	202	32	86	71	13	11	7	4	4	4	—
Surgery	130	123	20	51	43	9	7	4	3	—	—	—
Orthopedics	29	26	3	12	8	3	3	2	1	—	—	—
Obstetrics and Gynecology	103	88	14	39	29	6	9	5	4	6	5	1
Pediatrics	65	53	8	23	20	2	4	3	1	8	5	3
Otorhinolaryngology	51	46	5	9	29	3	4	—	4	1	1	—
Eye-Ear-Nose-Throat	5	5	—	3	2	—	—	—	—	—	—	—
Ophthalmology	48	41	5	13	17	6	5	2	3	2	1	1
Neurology and Psychiatry	61	49	8	22	17	2	2	1	1	10	3	7
Radiology	26	24	5	9	9	1	2	1	1	—	—	—
Urology and Proctology	46	41	2	15	20	4	5	2	3	—	—	—
Dermatology and Syphilology	26	22	3	10	7	2	3	1	2	1	1	—
Clinical Pathology	17	17	3	1	11	2	—	—	—	—	—	—
Anesthesiology	26	23	5	12	5	1	—	—	—	3	3	—
Physical Medicine	2	2	—	1	—	1	—	—	—	—	—	—
Industrial Medicine	2	2	—	1	1	—	—	—	—	—	—	—

It is readily seen that the white male physicians are heavily predominant, constituting 81 per cent of the total number. Of these white male physicians, 54 per cent are under 45 years of age and 14 per cent under 35 years. Only 9 per cent are 65 years or more.

In connection with the numbers of specialists, it needs to be pointed out that the physician's statement as to whether he was a specialist was accepted. That this was a valid measure is proved by the fact that of 981 physicians on the referral lists of the Medical Society of the District of Columbia, there were just 25 posted as general practitioners who considered themselves specialists. Of the 1,324 physicians in practice, only 35 per cent of the total are general practitioners. The percentage among white male physicians is 29. The figure is higher among females, 40 per cent, and highest among the Negro physicians, 71 per cent. Among male physicians, internists, surgeons and obstetricians constitute over half the specialists. Among females, instead, leaning is toward psychiatry and pediatrics. It will be observed that the general practitioners are older, on the average, than the specialists. This is in line with the recognized tendency among the younger men to specialize from the outset.

To be meaningful the number of physicians must of course be related to the population. At present, the ratio—on the basis of a population of 843,000—is 637 persons per physician. But in this respect, the District of Columbia cannot be considered apart from its surrounding counties since the whole metropolitan area in effect constitutes one medical trade region with Washington as its center. In the counties of Montgomery and Prince Georges, Maryland, and Arlington County and the City of Alexandria, Virginia, there are at present an estimated 324 active private practitioners. Thus, the total number of physicians in the metropolitan area equals 1,648, and the number of persons per physician is 762.

Comparison with Previous Surveys

The first of these studies of Washington's physicians was made in September 1942, when a substantial number had already entered the armed forces. The count at that time showed that there were 991 physicians in the District of Columbia. By April 1943 the number had fallen to 910, the same number to be found in April 1945. For the entire metropolitan area in 1945 the number of physicians was 1,048. The number of persons per physician at this time equaled 1,018 for the District of Columbia and 1,250 for the metropolitan area. Comparison with the present shows that, in the last two years, there has been a 45 per cent increase in the number of physicians in the District of Columbia and a 57 per cent increase for the metropolitan area as a whole. It is important in this connection to observe that, in relative terms, a far greater increase in number of physicians has taken place in the suburban communities than in the District itself. In the four suburban places mentioned, the absolute number of physicians has more than doubled, from 138 to 324.

As was to be expected, the increase has occurred largely in the younger age groups because they are made up in the main of physicians coming out of military service and of young men who have never before been in private practice. Among the male white practitioners, there has been an increase of 365 physicians since April 1945, and 287 of these are under 45 years of age. The increase has had its effect on the distribution of physicians by type of practice since there are now 314 more specialists. The greatest increase in specialists has taken place among the internists, the number having almost doubled since the 1945 survey. Surgery also shows a very sizable increase. Other specialties which have increased over 50 per cent are, in order, psychiatry, orthopedics, dermatology, urology and proctology, and radiology.

Comparison with Prewar Data

It is obviously important to compare the present situation with that existing before the War. But such comparison is difficult because of the unreliability of prewar data. The only figures available are based on medical directories. These do not give a clear picture of the supply of physicians in large metropolitan areas, such as Washington, because they list interns, residents, and physicians engaged in a variety of medically connected occupations other than private practice. The best estimate that can be made is that there were in 1941 approximately 1,330 physicians in practice in the District of Columbia proper and approximately 1,510 in the metropolitan area. In terms of persons per physician the ratios were 570 for the District and 707 for the whole area. It is felt that the figures on the numbers of physicians are maxima and that there were actually fewer active private practitioners at the time. If this assumption is correct, it would indicate that two years after the end of the War the number of persons per physician is already at the prewar level, or perhaps even smaller.

PATIENT LOAD

It has been the practice in these surveys to accompany each count of physicians with a questionnaire on the number of patients seen in one week. The reason for this is that the number of physicians and the ratio of physicians to population, without other information, do not provide sufficient knowledge about physicians' services. The present questionnaire was a simple one, asking only for the number of patients seen during the week of June 22 to June 28, 1947. Replies were received from 58 per cent of those queried. This percentage is slightly smaller than the 60 to 63 per cent obtained in previous surveys.*

The response from white male general practitioners was 55 per cent and from white male specialists 65 per cent. Thirty-four per cent of the Negro male physicians and 57 per cent of the female physicians returned their questionnaires. The age distribution of those who replied agrees fairly closely with the age distribution of all practitioners in Washington. Closest agreement occurs in the general practice and more numerous specialty groups.

The averages of the patient loads reported by the white male general practitioners are presented in table 2. Corresponding data are included for the studies made in 1942 and 1945. It is obvious at once that there has been a sharp drop in the patient load of the general practitioners as a group. The decline from February 1945 to June 1947 is of the magnitude of over 40 per cent. As will be seen in table 3, all the major specialties show similar decreases.

All three places where patients are customarily seen—office, home and hospital—are affected by the decrease. Hospital and home calls are approximately a half to a third of previous findings. By far the sharpest decline is noted among the younger physicians. This may be accounted for by the high proportion of newcomers in this group. When the physicians are divided into established and new practitioners, there is a significant difference in patient load between the two groups. Among the white male general practitioners under 45 years, for example, the average patient load of the new physicians is 49 as compared with 101 for physicians already established in practice in February 1945. Corresponding figures among the internists under

TABLE 2

Average Weekly Patient Load of White Male General Practitioners, September 1942, February 1945, and June 1947*

AGE GROUP (IN YEARS)	NUMBER OF PHYSICIANS GIVING INFORMATION	WEEKLY PATIENT LOAD					
		Averages				Standard deviations	
		Total	Office	Hospital	Home of patients	Total	Office
September 1942							
All ages	156	115	86	8	21	84	68
Under 35	26	127	96	8	23	66	49
35–44	58	135	102	10	23	87	76
45–64	43	118	89	7	22	90	68
65 and over	29	58	40	3	15	52	40
February 1945							
All ages	181	133	96	7	30	85	67
Under 35	18	138	97	7	34	84	63
35–44	64	142	102	8	32	67	53
45–64	75	144	106	7	31	97	76
65 and over	24	75	49	5	21	57	44
June 1947							
All ages	157	78	64	3	11	65	56
Under 35	23	64	51	2	11	41	35
35–44	64	93	78	3	12	77	70
45–64	50	80	65	4	11	56	48
65 and over	20	44	34	2	8	33	27

* Number of different individuals.

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* In the 1943 survey a response of 86 per cent was obtained because a follow-up questionnaire was sent to the physicians who did not answer the first query.

45 years are 34 for the new physicians and 72 for the others. The figures are based on rather small numbers of physicians and are subject to wide limits of error, in the statistical sense. Nevertheless, they indicate that the patient load of general practitioners and internists in established practice have been reduced by approximately 25 per cent in the past two years as a result of the increase in physicians.

TABLE 3

Average Weekly Patient Load of White Male Physicians Engaged in Practice Limited to Special Fields, 1942, 1945 and 1947*

YEAR OF SURVEY	NUMBER OF PHYSICIANS GIVING INFORMATION	AVERAGE WEEKLY PATIENT LOAD			
		Total	Office	Hospital	Home of patients
Internal medicine					
1942	50	95	71	10	14
1945	60	115	91	11	13
1947	113	64	53	4	7
Surgery					
1942	37	95	66	21	8
1945	42	88	62	18	8
1947	87	60	43	15	2
Obstetrics and gynecology					
1942	31	99	75	16	8
1945	29	122	99	20	3
1947	53	72	62	9	1
Pediatrics					
1942	27	95	62	10	23
1945	20	147	81	12	54
1947	36	100	77	7	16
Ophthalmology and otorhinolaryngology					
1942	40	99	89	7	3
1945	41	144	134	7	3
1947	57	72	67	4	1
Neurology and psychiatry					
1942	13	31	20	10	1
1945	17	40	31	6	3
1947	27	34	31	2	1

* Number of different individuals.

Another interesting feature of the data is the concurrence of the age pattern with that found in the 1942 studies. These studies, made in the District of Columbia, Maryland and Georgia[4, 5] consistently found that among white male general practitioners the 35–44 year group saw the most patients. The studies seem to show that at about 40 years of age physicians reach a crest in the number of patients they see, after which, in terms of patient load, their activities decline gradually.

The volume of different patients seen in one week by the male white specialists who replied in sufficient number is shown in table 3, with data of the 1942 and 1945 studies added for comparison. In all the specialties shown, a decrease in patient load has taken place since 1945. Although the decreases are in general somewhat smaller than that observed for the general practitioners, they are still considerable. For example, the patient load of the internists has decreased by 44 per cent, that of the surgeons by 32 per cent. The decrease from 1942 is not as great, and it is to be noted that the patient load of pediatricians and psychiatrists is now actually greater than it was then.

Although the data are not shown, mention should be made that a reversal in the age-group differences seems to have occurred. In each specialty, except pediatrics, the men 45 years of age and over are seeing more patients than the younger physicians. This may be a result of the War when civilian physicians—on the average, the older physicians—acquired many new patients whom they still retain. At the same time, the patient load of the younger physicians as a group reflects the large proportion of newcomers among them.

The patient load of the Negro physicians shows (a) a marked decrease—from 107 in 1942 to 64 at present (table 4), and (b) a shift in patient load to the older age groups. In 1942, average patient load reported by Negro physicians under 45 years was 151 as against 63 among the older physicians. Now no difference appears to exist, the average patient loads being 63 and 64, respectively. Female physicians show a proportionately smaller decrease in patient load, from 86 in 1942 and 90 in 1945 to 73 in 1947.

The decreases in patient load that have been observed were to be expected in view of the increase in

TABLE 4

Average Weekly Patient Load of Negro Male and of Female Physicians, 1942, 1945 and 1947*

YEAR OF SURVEY	NUMBER OF PHYSICIANS GIVING INFORMATION	AVERAGE WEEKLY PATIENT LOAD			
		Total	Office	Hospital	Home of patients
Negro males					
1942	48	107	78	6	23
1945	52	93	70	2	21
1947	61	64	54	1	9
Females					
1942	19	86	62	10	14
1945	43	90	74	6	10
1947	28	73	67	2	4

* Number of different individuals.

total number of physicians. It is of interest to point out that the decrease observed for the white male general practitioners could have been predicted on the basis of the earlier studies in which a relationship between patient load and ratio of population to physicians was formulated (see figure 5 in reference 5). It could have been calculated that with a ratio of 637 persons per physician, the average patient load of the general practitioner would be approximately 75, as found here. More will be said on this point in a later paper, but it is worth pointing out that for the range of population-physician ratios covered in these studies, a straight line relationship appears to exist between the number of patients physicians see and the number of persons per physician in the population.

If it is correct to assume that the ratio of physicians to population has about reached its prewar level, then one would anticipate finding that the patient load reported in this study is the same as it was before the War. In this connection there can be cited a recent study by the American Medical Association of medical care for civilians during World War II.[6] In that study, a sample of approximately 1,300 physicians reported their change in patient load between 1941 and 1944. From their data, it can be calculated that the average patient load was 43 per cent less in 1941 than in 1944. This corresponds fairly closely with the decrease in patient load observed here between 1945 and 1947.

SERVICES AND TYPE OF PRACTICE

The decrease in patient load which has taken place since the War is consistent with the increase in physicians. However, variations by type of practice in the increase of physicians and decrease in patient load suggest that some change is taking place in the pattern of medical services received by the population. To examine this change, the rate of utilization of physicians' services by the population has been computed for male white general practitioners and the specialists denoted in table 3. This rate expresses the number of patients per 1,000 population who, during one week, are seen by a physician. It has been computed by multiplying the total number of male white general practitioners and selected specialists in the city by the respective average patient loads. The results are shown in table 5 for three surveys.

TABLE 5

Number of Weekly Patients per 1,000 Population, 1942, 1945 and 1947

White Male Physicians

TYPE OF PRACTICE	YEAR OF SURVEY		
	1942	1945	1947
General Practice	43.0	39.4	28.8
Internal Medicine	11.5	14.7	15.3
Surgery	8.7	8.6	8.8
Obstetrics and Gynecology	7.9	7.7	7.5
Pediatrics	4.6	5.8	6.3
Ophthalmology and Otorhinolaryngology	10.0	12.0	7.8
Psychiatry	.8	.9	2.0
Total	86.5	89.1	76.5

The most striking finding is the decrease in patients seen by general practitioners. While the rate of utilization of such practitioners was 43 weekly patients per 1,000 population in 1942, the rate has now been reduced to approximately 29. Demand for ophthalmologists and otorhinolaryngologists also shows a variation in the three periods, the rate rising from 10 patients per 1,000 population in 1942 to 12 in 1945 and dropping to 8 in 1947. Very little change is to be observed for surgeons and obstetricians and gynecologists, while a slight but steady increase in rate is noted for internists, pediatricians, and psychiatrists.

Sex Life of the Pollen

Hayfever sufferers were given a measure of consolation yesterday by the straight-faced District Medical Society—the sneezers are shattering the gossamer wings of ragweed romance.

Every sneeze comes between a boy and his ragweed girl friend. It's the male pollen that causes the sneeze. There he is, floating in the summer zephyrs looking for a wife and family, and what happens? He gets tangled up in somebody's Jimmy Durante. He's probably the most frustrated guy in the weedpatch.

Yesterday, though, it was the rain that got in the pollen's way. The Medical Society's count for the 24 hours ending at 9:30 a.m. yesterday was 18—incomplete due to rain—but still this year's highest.

—*Times-Herald, Washington, D.C., August 23, 1947*

In the sum for these practitioners, the rate of utilization has decreased from 86.5 to 76.5 patients per 1,000 population, but whether this decrease represents a chance fluctuation or is significant cannot be determined. It may reflect economic changes in the city's population or the drawing off of patients by the great increase of physicians in the suburban areas. In any event, the demand for general practitioners' services has diminished considerably, with some compensatory increases being shown in the demand for the internists, pediatricians, and psychiatrists.

Summary

The fourth in a series of surveys on the number and patient load of Washington, D. C., physicians reveals:

1. There are, as of June 1, 1947, 1,324 active private practitioners in the District of Columbia. The number of persons per physician is 637. In the entire metropolitan area, there are 1,648 physicians—a ratio of 762 persons per physician.

2. White males make up 81.3 per cent of all physicians in the District of Columbia, Negro males 14.3 per cent, and females 4.4 per cent. A little over half the male white physicians are under 45 years of age, 9 per cent are 65 years or more. General practitioners constitute less than 30 per cent of the total number of white male physicians.

3. The present number of physicians in the District of Columbia represents an increase of 45 per cent over 1945 (910). The increment is made up largely of men under 45, most of whom are specialists.

4. Although a precise comparison cannot be made, there is reason to believe that the prewar ratio of population to physicians has about been reached.

5. The patient load of physicians—the number of different individuals seen in one week—has declined considerably since the peak reached before the War's end. The average patient load reported by white male general practitioners is 78, as compared with 115 in September 1942 and 133 in February 1945. The various specialties showed similar changes.

6. The rate of utilization of physicians' services shows a marked decrease in the demand for general practitioners' services, with some compensatory increase being shown in the demand for the internists, pediatricians, and psychiatrists.

BIBLIOGRAPHY

1. Ciocco, A., Pond, M. A., and Altman, I.: Survey of practicing physicians in Washington. M. Ann. District of Columbia, 1942, **11**, 454.
2. Ciocco, A., and Altman, I.: On decrease of practicing physicians in Washington, D. C. Ibid., 1943, **12**, 407.
3. Ciocco, A., and Altman, I.: Changes in number and patient load of physicians practicing in Washington, D. C. Ibid., 1945, **14**, 223.
4. Ciocco, A., and Altman, I.: Statistics on patient load of physicians in private practice. J. A. M. A., 1943, **121**, 506.
5. Ciocco, A., and Altman, I.: Patient load of physicians in private practice. Pub. Health Rep., 1943, **58**, 1329.
6. Dickinson, F. G.: Analysis of questionnaires on medical care of civilians during World War II. J. A. M. A., 1947, **134**, 369.

MEETINGS

Wednesday, November 12

Speakers and subjects to be announced.

Wednesday, November 19

The Diabetes Association of the District of Columbia, Inc., will present the following program:

"Clinical Approach to Diabetes," Elliott P. Joslin, M.D., F.A.C.P., Medical Director, George F. Baker Clinic, New England Deaconess Hospital, Boston

"The Romance of Insulin," Charles H. Best, M.D., Professor of Physiology, University of Toronto

Queries and Answers

Editor's Note: This is the first appearance of a new section of the Medical Annals. Its future will depend upon the interest shown in it by readers. As stated in a communication directed to members, answers to queries are made by those who, in the opinion of the Editor, are best qualified to reply to them. The Editor does not necessarily endorse the answers given.

Q. *What is the best age to start chorionic gonadotropin for unilateral intracanalicular cryptorchidism? Please give dosage and interval. Are precocious side effects permanent? How soon after medical treatment and at what optimal age is surgery indicated?*

A. Six to 8 years is the best age to start endocrine treatment. Gonadotropin in a dose of 500 units 3 times a week for four to six weeks is recommended. Precocious side effects are not usually permanent, but may be. Surgery is indicated at least on one side in bilateral cases before the 8th year, and as early as the 3rd year. In the unilateral cases the time can be selected by the patient or family but it should be kept in mind that 90 per cent of testicles not in the scrotum before the 6th or 8th year will be sterile and that their endocrine function may be lost.

Q. *What changes occur in the kidney from death due to anoxia?*

A. The gross appearance of the kidney in death due to anoxia is indistinguishable from that seen in lower nephrone nephrosis. They are enlarged, soft, and on section reveal a pale, thick, ischemic cortex. The medullary markings are distinct due to congestion. Microscopically the glomeruli appear unchanged. The convoluted tubules, however, reveal advanced degenerative changes with their lumina filled with epithelial debris casts and often blood. The stroma is edematous. The above picture may result from innumerable conditions including burns, trauma, transfusion reactions, shock, etc., and is not specific for any one.

Q. *What is the value of benadryl in poison ivy?*

A. The use of benadryl in the treatment of poison ivy and in other forms of contact dermatitis has been reported. Most writers have treated only a very small number of patients in their series. This makes a clear cut appraisal difficult. The use of an intravenous solution of benadryl in the treatment of a few patients with poison ivy has resulted in almost immediate cessation of itching. It is felt that the use of the intravenous solution is a satisfactory objective method of testing the efficacy of the drug. It is believed that oral benadryl will often relieve the pruritus associated with contact dermatitis but will not change the course of the disease.

Q. *What is the legal status in the District of Columbia on bilateral vasectomy?*

A. There is no law covering vasectomy in the District of Columbia. In the case of a married man who is to have vasectomy, some hospitals use forms to be signed by both man and wife for additional legal security. A most interesting and comprehensive paper will be published in the *Journal of Urology* by Vincent J. O'Conner of Chicago on the legal status throughout the United States and practical aspects of vasectomy and vas anastomosis.

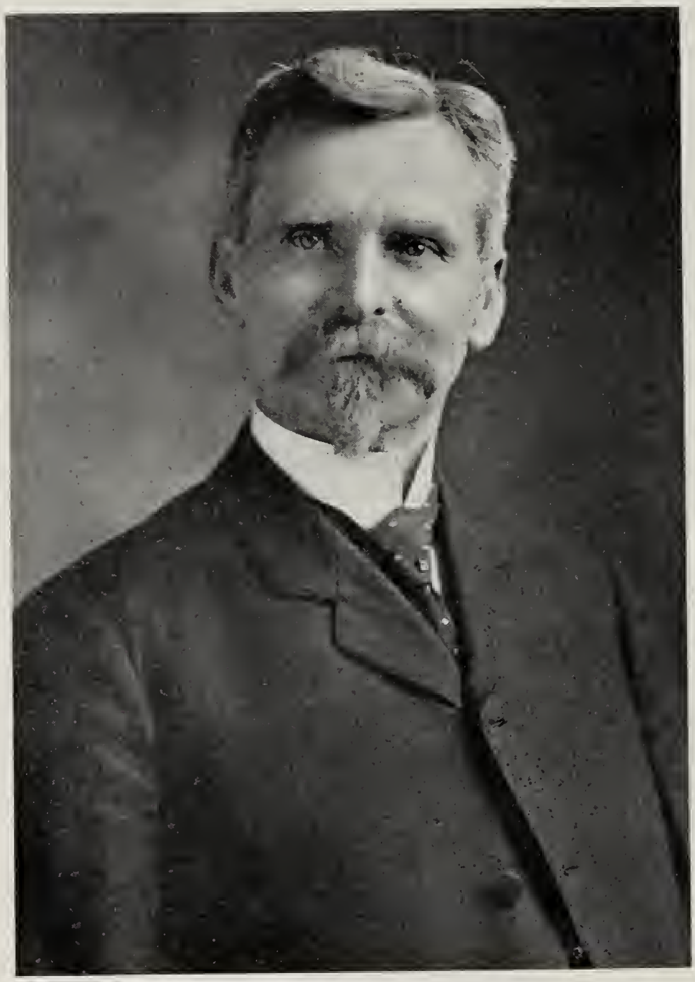
Q. *In the absence of previous immunization, is immunization with toxoid or antitoxin (tetanus) the more desirable and effective at the time the wound is received? With what frequency should booster doses of toxoid be administered?*

A. When tetanus toxoid has not previously been given, tetanus antitoxin affords the only safe protection at the time a wound is received. When toxoid immunization has previously been accomplished, a booster dose of 1 c.c. of fluid tetanus toxoid should be given at a time of injury. Apart from the use of a booster dose when a wound is received, booster doses should be given annually after the initial immunization in order to insure continued protection.

Important Notice to Physicians

The District of Columbia Department of Vehicles and Traffic requests that each physician check his driver's license carefully to make sure that it has not expired. In previous years the Department has notified drivers that their licenses were expiring. Unfortunately, due to shortage of personnel, only a few such notices were sent out this year; therefore, the procedure has been discontinued temporarily although it may be resumed. In the meantime, NOTE THE EXPIRATION DATE OF YOUR DRIVER'S PERMIT AND HAVE IT RENEWED IF IT HAS EXPIRED.

Washington Physicians of Yesterday



ISAAC SCOTT STONE, M.D., Sc.D., LL.D.

During the decades at the turn of the twentieth century there was a group of able and distinguished gynecological surgeons who flourished in the city of Washington, including: Joseph Taber Johnson (1845–1921), Isaac Scott Stone (1851–1935), Henry D. Fry (1853–1919), Henry L. E. Johnson (1858–1915), John Wesley Bovée (1861–1927), Gideon Brown Miller (1861–1937), Albert L. Stavely (1863–1939), and John Thomas Kelley, Jr. (1863–). These are all worthy of biographical commemoration among distinguished Washington physicians of the past; but the career of Dr. Stone will be here presented as a typical representative of the group.

Dr. Isaac Scott Stone was born March 1, 1851, at Sandy Spring, Maryland, near Washington. From the University of Maryland he received the degree of M.D. in 1872, and of Sc.D. in 1907; and from Georgetown University the degree of LL.D. in 1921. From 1872 to 1890 he practiced medicine in Lincoln, Loudoun County, Virginia, where he married Thomasin J. Taylor, November 16, 1875.

His interest being early attracted to gynecology, he attended gynecological clinics in New York City in 1882; and in Birmingham and London, England, in 1888. He removed to Washington, D. C., in 1890, where he was

(*Continued on page 594*)

NATIONAL HEARING WEEK—NOVEMBER 9-15, 1947

The American Hearing Society and its 120 affiliated chapters will this year observe National Hearing Week from November 9 to 15. The theme, "Time to Conserve Hearing," is brought out by attractive poster displays of a little girl listening to a clock.

The local chapter, the Washington Society for the Hard of Hearing, a Red Feather agency, is planning a series of special events, laying stress on the importance of the otologist in the prevention of deafness program. Located at 2431 14th Street, N.W., the Society will sponsor a tea at its headquarters on Sunday, November 9, from 3 to 6 p.m. At this time the newly appointed Consulting Board of Otologists for the Society's hearing aid consultation service will be announced and the members introduced.

The hearing aid consultation service is an important part of the Society's social welfare program. Here clients may come for an unbiased opinion on the type of hearing aid best suited to his particular hearing loss. If the client has not yet visited an otologist, he is urged to do so. If the client has been given an audiometer test by the otologist, he is asked to bring the audiogram with him; otherwise he is given an audiometer test at the Society. It is then determined whether a bone or air conduction receiver should be worn. Only those aids approved by the Council on Physical Medicine of the AMA are demonstrated in the service. Each client is tested with the various aids by word, sentence and conversation tests until it is finally decided with which aid he hears the most clearly. The client is referred to the local dealer for a fitting but comes back to the Society for a recheck and further help in becoming adjusted to the aid.

The Chairman for Hearing Week, Mrs. Edna Kury Monsees, has announced that visitors will be welcome to observe the service in action during part of the "Go See" tours which have been arranged through the local Community Chest.

Other events of the Week will include a demonstration of the phases of lip reading on November 13, at 8 p.m., when Miss Frances Downes conducts a "Let's Look at Lip Reading" program, radio broadcasts emphasizing the need for acquainting the public with facts about impaired hearing, and talks at civic meetings featuring the fact that much deafness can be prevented by prompt medical attention, particularly during and following those childhood diseases that so often leave deafness in their wake.

The Washington Society for the Hard of Hearing, through its Executive Secretary, Miss Rose V. Feilbach, has always worked closely with the D. C. Medical Society. When Dr. X found that two-year-old Bobby had a hearing loss, he knew he could depend on the Society for the Hard of Hearing to advise the mother on the education of her child. The instructors there gave her hints on how to start his lip reading at home; they made him aware of whatever sound they could by means of amplifiers, bells, horns and music. When Dr. Y had old Mrs. Jones at the clinic and found she needed a hearing aid, he referred her to us and she was given a used aid for a "permanent" loan, for she could not afford to pay for any such prosthesis. When Dr. Z found that Miss Smith needed to mingle with a few other hard-of-hearing folks to find out she was not the only young person in the world with a hearing loss, the Washington Society for the Hard of Hearing proved to be the starting point in her rehabilitation. Young and old alike have found a use for the many services given by this community agency not only during Hearing Week, but throughout the year.

THE PHYSICIAN AND THE COMMUNITY CHEST

In a very real and practical way, the role of the physician in the care of children is closely linked with the role of the Community Chest and its Red Feather agencies, which provide free or part-pay convalescent care.

Without the kind of care provided through the Children's Country Home, for example, many children up to six years old would not get the proper medical and nursing care they need to get well following an operation or illness, or because of malnutrition.

And without the coöperation of skilled doctors and an adequate nursing staff, the Home would be unable to use Chest funds to provide that care.

The Home is an attractive, rambling building at 18th and Bunker Hill Road, N.E., with quarters for 37 white children, playground, a fine, sunny playroom, highly specialized tot-size equipment, laboratory, modern laundry and kitchen, and a competent staff supervised by a large, active board of Lady Managers.

It gets 85 per cent of its operating budget from the Community Chest of Washington. Physicians, hospital social service departments, and welfare agencies refer to its staff the boys and girls whose own homes cannot provide the convalescent care they need. A typical case is that of 5½-year-old Bobby, whose doctor sent him there a few months ago to recover from rheumatic fever.

Bobby had done well in his two weeks in a hospital. However, had he been sent home, with his grandparents, he would have missed the thing he needed most, professional medical care during recuperation.

At the Home, with its cheerful rooms, efficient staff, and regular examination by physicians, Bobby prospered. At the end of a month's stay, heart murmurs audible when he was admitted could no longer be heard.

His family was grateful that the doctor knew about the help available at Children's Country Home. But the beds here are seldom all occupied. With its two physicians, five graduate nurses (one being the Superintendent), two undergraduate nurses, and 8 nurses' aides, this fine Home should have a waiting list.

Maybe physicians would be interested in talking with Miss Elizabeth Van Wagner, Superintendent, to become better acquainted with the facilities here.

Out in Rockville is another similar convalescent home, Christ Child Farm for Convalescent Children, for white children from 6 to 12, also supported by the Community Chest. Free care is available at both institutions, with part-pay care fees scaled to parents' ability to pay and available to all who are eligible.

Physicians have always shown the deepest interest in child welfare. But this is only one phase of the necessary community services provided through the annual campaign of the Community Chest Federation which opens November 12. Objective is to raise $3,900,000 for 125 Red Feather Services for 1948 operation.

Physicians can share in the work of providing necessary care to those in need through wholehearted, generous contributions to the campaign.

U. S. PUBLIC HEALTH SERVICE RESEARCH FELLOWSHIPS

The Surgeon General of the USPHS has been given the authority to establish and maintain research fellowships which are intended to promote the training and development of investigators in the field of medicine and related sciences. Members of the Medical Society may be interested in the postdoctorate research fellowship which is awarded to qualified persons holding a Doctor's degree in medicine or in related fields. This fellowship does not provide tuition fees but carries a stipend of $3,000 per year for doctors without dependents and $3,600 per year for those with dependents. An increase of $300 each year is granted to those Doctorate Fellows who are reappointed.

Predoctorate research fellowships for applicants having a Bachelor's degree and Master's degree, as well as for medical students, are also available.

Fellowships are awarded for one-year periods and may be renewed. Except in unusual circumstances, Postdoctorate Fellows are not reappointed for a third year.

Although research fellowships are awarded approximately every three months, the effective date for beginning fellowship work can be set at any time to suit the convenience of the successful applicant and the institution in which he will be working. Application forms may be obtained from the Division of Research Grants and Fellowships, National Institute of Health, Bethesda 14, Md.

During the period between January 1, 1946, and August 31, 1947, 699 research projects under the National Institute of Health Research Grants-in-aid Programs had been activated, from a total appropriation of $10,214,174. The 23 fields of study represented in this program ranged "from A to V," i.e., from Antibiotics to Virus and Rickettsial.

Georgetown University School of Medicine and the Warwick Memorial Clinic for Cancer and Allied

Diseases have been awarded large sums for cancer research. The individuals who are directing the research in these institutions were listed in the August issue of the MEDICAL ANNALS. Projects in other fields of medicine are also being carried on locally by USPHS funds. Among those not previously published in the ANNALS are the following:

"Streptomycin in Diarrhea," $7,998, Dr. Frederick G. Burke, and "Rheumatic Fever," $9,090, Dr. Mark P. Schultz, both at Children's Hospital.

"Toxic Reactions from Penicillin," $10,557, Dr. Harry F. Dowling, and "Antibiotics from Fungi and Higher Plants," $3,583, Dr. Monroe J. Romansky, both at George Washington University School of Medicine.

"Penicillin in Syphilis," $3,586, Dr. George D. Weickhardt, St. Elizabeths Hospital.

The Washington School of Psychiatry will receive $13,850 for "psychiatric and sociological study of a mental hospital ward," to be administered by Dr. Alfred H. Stanton. The study will be made at Chesnut Lodge Sanitarium, Rockville, Md.

CALENDAR OF MEETINGS

September 3	Chairmen of Committees
September 9	Registered X-ray Technicians of Washington
September 10	Section on Otolaryngology
September 12	Subcommittee on Mental Health
September 13	Washington Psychoanalytic Society
September 15	Former members of District Selective Service System
September 16	Grievance Committee
September 18	Committee on Sports
September 22	Executive Board
September 23	Association of Undergraduate and Practical Nurses of the District of Columbia
September 26	Subcommittee on Public Health Exhibit, 18th Annual Scientific Assembly
	Section on Otolaryngology
September 30	Presiding officers for A.S.A.

NEW POSTGRADUATE COURSES AT GEORGE WASHINGTON UNIVERSITY

Elsewhere in this issue (page ix) there is an announcement of the intensive postgraduate courses to be offered by the George Washington University School of Medicine during the current academic year. This will be the third successive year in which a series of postgraduate courses has been presented by the School of Medicine. Previous courses have attracted physicians from many states and from several foreign countries. A feature of these courses has been the large number of distinguished physicians from other cities who have taken part.

Sixteen fulltime courses are offered, extending from the middle of January until the middle of April. By combining these in a logical sequence, courses varying from one to seven weeks in duration can be arranged. Although planned primarily to bring the physician up to date in various fields, these courses also serve admirably as a review in preparation for specialty board examinations.

For the first time this year, two part-time evening courses will be presented. These are planned for physicians practicing in Washington and vicinity. The first, "Clinical Electrocardiography," will be presented at the School of Medicine each Tuesday evening from 8:00 to 10:00 p.m., beginning on December 2, 1947 and extending through January 20, 1948.

The other part-time course will be a series of twelve or more evening sessions held once or twice a week beginning the last week of January. This course will be announced in more detail in a later issue of the ANNALS and a bulletin describing it will be distributed by mail. At each session a topic of current interest will be presented by some outstanding authority in the field. The topics will appeal to all physicians and will present information for use in everyday clinical practice.

These courses provide a greater variety of subjects than has been available in previous years and represent a most comprehensive program of postgraduate instruction.

News and Personals

The Annual Meeting of the Southern Medical Association will be held in Baltimore, November 24, 25 and 26. The registration booth, the majority of the meetings, and the scientific and technical exhibits will be found at the Fifth Regiment Armory on Hoffman Street. Other meetings will be conducted at the home of the Medical and Chirurgical Faculty of Maryland and the Baltimore City Medical Society, 1211 Cathedral Street, near the Armory. All hotel reservations should be made through the Hotel Committee, Southern Medical Association Meeting, 1714 O'Sullivan Building, Baltimore 2, Md.

The American College of Allergists announces a Fall Graduate Instructional Course in Allergy under the auspices of the College of Medicine of the University of Cincinnati, Ohio, November 3–8. The lectures will be given in the auditorium of the Medical College. The hotel headquarters is the Netherland Plaza.

Dr. Harry S. Bernton of Washington will be one of the speakers, November 3. He will discuss "The Clinical Significance of Recent Chemical Studies of Allergens."

The Salmon Committee on Psychiatry and Mental Hygiene of the New York Academy of Medicine has selected Dr. Harold Dwight Lasswell, Professor of Law at Yale University and internationally known political scientist, as the **Salmon Lecturer for 1947.** Dr. Lasswell will give three lectures, November 12, 13 and 14, in the New York Academy of Medicine, 2 East 103rd Street, New York City. Members of the medical profession and their friends are invited to attend.

The American Association for the Study of Goiter again offers the **Van Meter Prize Award of $300** and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association, which will be held in Toronto, Canada, May 6–8, 1948, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English; and a typewritten, double spaced copy sent to the Corresponding Secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Ga., not later than February 1, 1948.

The Silver Spring Academy of Medicine will meet regularly on the first Monday of each month, between September and May, at the New Montgomery County Building, Colesville Road, near Georgia Avenue, Silver Spring, beginning at 8:15 p.m. Physicians who practice in the Silver Spring-Takoma Park-North Washington-Kensington area, and who are members of either the District of Columbia Medical Society or the Montgomery County Medical Society, are invited to become members of the Academy and to attend the meetings.

On Monday night, November 3, Dr. Emil Novak, Assistant Professor of Gynecology, Johns Hopkins University, will speak on "Indications, Limits, and Hazards of Endocrine Therapy in Gynecology." Dr. Raymond T. Holden, President of the District Medical Society, will discuss the paper.

On September 8 Dr. Monroe J. Romansky was the guest speaker; his subject, "Clinical Use of Penicillin and Streptomycin." On October 6 Dr. T. Wiley Hodges gave an address on "Reconstructive Surgery of the Spine and Extremities." Dr. W. J. Tobin discussed the paper. Programs during the rest of the year will be announced each month in the Medical Annals.

Dr. William W. Stanbro, chief roentgenologist at George Washington University Hospital, will address the next monthly meeting of the **Society of Registered X-ray Technicians,** November 11, at 8 p.m., in the Medical Society's Library.

The President of the Woman's Auxiliary to the Medical Society of the District of Columbia, Mrs. Robert E. Moran, has requested the Editorial Board to extend, through the MEDICAL ANNALS, a cordial invitation to all wives of members of the Medical Society who are not now members of the Auxiliary to affiliate with it this year. The Chairman of the Membership Committee is **Mrs. John J. Shugrue,** 2540 Massachusetts Avenue, N.W. Mrs. Shugrue will appreciate a note or a telephone call from any physician's wife who is interested in joining the Auxiliary. Her telephone number is Dupont 7523.

The George Washington University School of Medicine began its 124th academic year with special opening exercises, September 15. Rear Admiral H. L. Pugh, Deputy Surgeon General of the U. S. Navy, gave the principal address; his subject was "The Shift of Emphasis in Medicine." Dr. Walter A. Bloedorn, Dean of the School of Medicine, and Dr. Cloyd Heck Marvin, President of the University, welcomed the new class of 86 students.

A portrait of **Dr. Howard Francis Kane,** who died July 21, 1946, was unveiled at the exercises by Mrs. Joshua Evans, Jr., a member of the University's Board of Trustees. Dr. Kane had been a member of the teaching staff of the School of Medicine for thirty years. From 1932 until a few months before his death, he was Executive Officer and Professor of Obstetrics and Gynecology. On May 28, 1946, he was appointed Professor Emeritus. His portrait, painted by Joseph Magulies, was a gift of the faculty of the School of Medicine and will hang in the new Hospital.

At the luncheon at the Mayflower Hotel which followed the convocation exercises, Senor Don Martin Luis Drago, Counselor of the Argentine Embassy, presented a set of atlases to the School of Medicine on behalf of the Ambassador.

A two-week orientation program was an innovation for this year's freshman class at George Washington's School of Medicine. This program was designed to acquaint students with medical terminology and to show them the relationship of medicine to physics, biology, sociology and chemistry. Lectures were also given on the evaluation of scientific evidence and basic sciences in medicine. Lecturers during this series were Dean Bloedorn; Dr. Thomas Peery, Director of the University's postgraduate instruction; Leo G. Schmelzer, Superintendent of the University Hospital; Dr. John Parks, Professor of Obstetrics and Gynecology; Dr. Brian Blades, Professor of Surgery; Dr. Ralph G. Beachley, Adjunct Professor of Public Health Practice; Dr. Winfred Overholser, Professor of Psychiatry and Superintendent of St. Elizabeths Hospital; Theodore Wiprud, Secretary of the Medical Society of the District of Columbia; Dr. Charles R. L. Halley, Clinical Professor of Medicine; Dr. Robert Cook, Managing Editor of the *Journal of Heredity;* Dr. Dale Stewart, Curator of Physical Anthropology, National Museum, Smithsonian Institution; and Dr. Louis Bryant Tuckerman, Assistant Chief, Division of Mechanics, National Bureau of Standards.

The following list of initiates, members of the Medical Society of the District of Columbia, were accepted into fellowship at the Thirty-third Convocation of the **American College of Surgeons** in New York on September 12 at the final event of the Clinical Congress: Drs. Walter Atkinson, Aaron H. Gerber, Herbert A. Goldberg, Benjamin Golden, Roy G. Klepser, Calvin T. Klopp, William R. Moses, Julius S. Neviaser, Carlton N. Price, Leo C. Varden and Samuel Zola.

The Section on Otolaryngology elected new officers for 1947–48 at its June meeting. They are as follows:

Dr. Allan E. Walker, *Chairman;* Dr. James P. Lyons, *Vice Chairman;* Dr. Richard W. Wilkinson, *Secretary;* Dr. Don S. Knowlton, *Treasurer.*

Former members of the District Selective Service System met in the Medical Society's auditorium, September 15, to make plans for setting up a permanent organization. According to the proposed Constitution, its purpose would be "to preserve the organization of the Selective Service System of the District of Columbia in order to make available for national defense, should the need ever occur, the experience and knowledge gained by its members in the years of their active service during World War II, and to continue the friendships and associations formed during those years of service."

About two thirds of those who participated in the District Selective Service System were physicians who served as local board physicians and members of the medical advisory boards as well as local and appeal boards.

Nine new appointments to the faculty of the **George Washington University School of Medicine** were recently announced. They are: Lt. Colonel Vernon D. Pettit, Professor of Military Science and Tactics; Drs. Thomas J. Pekin, Camp S. Huntington, Raymond Schwartz, Alvin V. Rouzer and George R. Taylor, Clinical Instructors in Medicine; Dr. R. Bretney Miller, Clinical Professor in Medicine; Dr. Warren Andrew, Associate Professor and Executive Officer of the Department of Anatomy; and Dr. Barbara Moulden, Instructor in Anatomy.

The Washington Society for the Advancement of Psychotherapy (see June 1947 issue of the ANNALS, page 347) was incorporated June 6, 1947, under the laws of the District of Columbia. The officers elected to serve are as follows:

Dr. Louis S. London, *President;* Dr. Leopold E. Wexberg, *Vice President;* Dr. Benjamin Karpman, *Executive Director and Secretary;* Dr. Philip Litvin, *Treasurer.*

The Washington Institute for Psychotherapy has also been organized and was incorporated on the same day as the Society.

The District of Columbia Rheumatism Society entertained at dinner, September 19, in honor of two out-of-town physicians, Dr. Richard Freyberg of New York and Dr. T. Duckett Jones of Boston, who were in Washington to discuss problems of arthritis with staff members of the National Research Council. Both physicians spoke informally to the group.

George Washington University has purchased the Everglades Apartments at 2223 H Street, N. W., at a cost of $400,000. The apartment building will be used to house the nurses on the staff of its new Hospital, which is now nearing completion at Washington Circle.

Dr. A. Barklie Coulter has been appointed Secretary to the Council on International Affairs of the American College of Chest Physicians. The following members comprise the Council: Dr. Herman E. Hilleboe, New York Commissioner of Health, Chairman; Dr. Chevalier L. Jackson, Philadelphia, Chairman of the Council of Pan American Affairs; Dr. Andrew L. Banyai, Milwaukee, Chairman of the Council on European Affairs; Dr. Harry C. Warren, San Francisco, Chairman, Council on Pan Pacific Affairs; and Dr. Coulter, newly appointed Secretary. The purpose of the CIA is to correlate the activities of the three College Councils listed.

At the request of Major Robert J. Barrett, Superintendent of Police, the District Commissioners instructed Health Officer George C. Ruhland to **assign doctors to all District ambulances.** Major Barrett made the request in order to relieve police of responsibility for diagnoses or death pronouncements in the absence of a physician. Dr. Ruhland favors sending interns with ambulances, a practice which was discontinued in the early days of the War, and will endeavor to obtain a ruling from the Corporation Counsel as to whether it would be legal for interns to serve as "doctors" in the District ambulances. He stated he would ask Casualty and Emergency Hospitals to supply the same type of medical service in ambulances as ruled necessary or ambulances operated from Gallinger.

Dr. Thomas Parran, Surgeon General of the USPHS, represented the United States at the Fourth Session of the Interim Commission of the World Health Organization, which met in Geneva, August 30 to September 13. At the conclusion of the Session he flew to Buenos Aires for the meeting of the directors of the Pan American Sanitary Bureau.

Dr. Ernest Sheppard will be guest speaker at Children's Memorial Hospital, Chicago, October 19–24, at a conference directed by Dr. George P. Guibor. Dr. Sheppard's lectures will be entitled, "Peripheral Eye Motor Defects" and "The Evaluation of Tests for Oculo-Motor Imbalances."

Dr. William P. Herbst was the guest lecturer at the U. S. Naval Medical School in Bethesda, Md., September 26. Dr. Herbst spoke on "Clinical Aspects of the Chemistry of Prostatic Malignancy."

This lecture, the first of the 1947–48 season, was given in the auditorium of the National Naval Medical Center, Bethesda. The Medical Department officers were hosts at refreshments following the lecture.

Dr. Winfred Overholser spoke at the centennial observance of the founding of the Jacksonville (Illinois) State Hospital, July 27. The subject of his address was "Jacksonville 1847—Psychiatry Then and Now."

Dr. Herbert M. Giffin, of Rochester, Minn., has been appointed general surgeon of the **Yater Clinic,** replacing Dr. Robert J. Coffey, who has become full-time Professor of Surgery at Georgetown University School of Medicine.

Dr. Giffin received his A.B. degree from Princeton University in 1931 and his M.D. degree from Johns Hopkins University School of Medicine in 1935. He was resident at the Graduate Hospital of the University of Pennslyvania from 1935 to 1937, following which he had five years of graduate training in general surgery at the Mayo Clinic. During World War II he served in the U. S. Navy, and during the past two years has been on the surgical staff of the U. S. Naval Hospital in Philadelphia, being identified with the thyroid, gastric and colon surgery and in charge of thoracic surgery. He was qualified by the American Board of Surgery in 1942 and is a Fellow of the American College of Surgeons.

Dr. Jay McLean, Associate Professor of Surgery at Ohio State University, has been appointed Chief of the newly established **Bureau of Cancer Control** of the District Health Department. Dr. McLean, a native of San Francisco, obtained his degree in medicine at Johns Hopkins University. He will assume his new post at the end of his present term at the University, where he has been engaged primarily in cancer control activities. The new Cancer Control Bureau was authorized by Congress in the 1948 budget. It will have appropriations totalling $61,000 in District and Federal funds with which to carry on an anti-cancer campaign in the District.

Dr. J. Ross Veal sailed on the Queen Elizabeth September 1 to attend the meetings of the Intersurgical Society in London, September 14–20, and to visit hospitals in Paris. He made the return voyage on the Queen Mary.

Friends of **Captain Lloyd R. Newhouser, M. C., U. S. N.,** now in charge of the graduate training program for the Bureau of Medicine and Surgery, will be pleased to learn that he received the Legion of Merit, August 22, for wartime achievement in planning the blood-substitute program in the Pacific war area, designing standard packages for serum albumin and penicillin, and devising a method for processing liquid plasma.

Dr. G. Foard McGinnes, chief of health services for the American Red Cross, addressed the meeting of the American College of Surgeons in New York, September 9, on the new national blood program.

Dr. Benjamin P. Lafsky gave a talk on "Allergy" before the Washington Nurses' Association, July 7. Dr. S. Arthur Linde addressed the group at an earlier meeting; he discussed penicillin and streptomycin.

New names to be added to the list of Society members who are participating in the programs of **Professional Staff Proceedings at Walter Reed General Hospital** are Drs. William P. Herbst, William T. Lady and George M. Wyatt.

Dr. A. B. C. Knudson, an Associate member of the Medical Society, was one of the speakers at the American Congress of Physical Medicine, which met in Minneapolis, September 2–6.

Mr. James G. Capossela, Administer of **Emergency Hospital,** was elected a member of the American College of Hospital Administrators at its meeting in St. Louis, September 21. He is one of 80 hospital administrators in the United States so honored.

CORRESPONDENCE

Washington, D. C., September 11, 1947

Mr. Theodore Wipurd
Secretary and Executive Director
D. C. Medical Society
1718 M Street, N.W.
Washington, D. C.

Dear Mr. Wipurd:

You will find enclosed copy of a letter which was forwarded to you under date of July 2, 1945 [see below].

The Commission on Licensure at a regular meeting held September 8, 1947 considered the application of a young man who has been practicing as an assistant to a local physician since May 26, 1947. Such practice is a violation of law and the physician-employer is also guilty of wrong-doing.

The Commission will not tolerate such looseness and instructed me to write you again. Will you, through your Society, again acquaint the profession with the fact that physicians assisting them must be licensed before commencing their duties. The matter might be cleared through your publications.

You may be assured your coöperation will be greatly appreciated.

Very sincerely,

George C. Ruhland, M.D.
Secretary-Treasurer,
Commission on Licensure,
Healing Arts Practice Act,
District of Columbia

(copy)

Washington, D. C., July 2, 1945

Mr. Theodore Wiprud, Secretary
D. C. Medical Society
1718 M Street, N.W.
Washington, D. C.

Dear Mr. Wipurd:

In considering a reciprocal application at the Commission meeting held June 26, 1945, it developed that the applicant served as an assistant in Anesthesiology to three local physicians. This, as you know, is a violation of the local medical practice act. The act is very specific (Section 43) on the activities that may be carried on legally (without license) under the direction of licensed physicians and anesthesiology is not included.

"Ignorance of the law is no excuse" and I feel the profession should be acquainted with Section 43 and its very definite limitations. Allowing a young physician to serve in the capacity of an assistant proves embarrassing at the time he applies for a license here. It should be borne in mind that the time to apply for a local license is *before* and *not after* he associates himself with local physicians.

Very sincerely,

George C. Ruhland, M.D.
Secretary-Treasurer,
Commission on Licensure,
Healing Acts Practice Act,
District of Columbia

Washington, D.C., September 16, 1947

Mr. Theodore Wiprud
Medical Society of the
District of Columbia
1718 M Street, N.W.
Washington, D. C.

Dear Mr. Wiprud:

You have requested my advice whether or not physicians are required to license their practices as unincorporated businesses in the District of Columbia and to pay an unincorporated business tax thereon under the provisions of the District of Columbia Revenue Act of 1947 approved July 16, 1947.

The Revenue Act of 1947 requires certain unincorporated businesses to secure licenses to carry on such businesses in the District of Columbia and imposes, for the privilege of carrying on such businesses in the District of Columbia, an annual tax at the rate of five per centum levied upon the taxable income of such businesses. The pertinent sections of the Act read as follows:

"Title VIII—Tax on Unincorporated Businesses

"Sec. 1. Definition of Unincorporated Business.—For the purposes of this article (not alone of this title) and unless otherwise required by the context, the words 'unincorporated business' mean any trade or business, conducted or engaged in by any individual, whether resident or nonresident, statutory or common-law trust, estate, partnership, or limited or special partnership, society, association, executor, administrator, receiver, trustee, liquidator, conservator, committee, assignee, or by any other entity or fiduciary, other than a trade or business conducted or engaged in by any corporation; and include any trade or business which if conducted or engaged in by a corporation would be taxable under title VII of this article. The words 'unincorporated business' do not include any trade or business which by law, customs, or ethics cannot be incorporated or any trade or business in which more than 80 per centum of the gross income is derived from the personal services actually rendered by the individual or members of the partnership or other entity in the conducting or carrying on of any trade or business and in which capital is not a material income-producing factor.

"Sec. 2. Taxable Income Defined.—For the purposes of this title, and unless otherwise required by the context, the words 'taxable income' mean the amount of net income derived from sources within the District within the meaning of title X of this article in excess of the exemption granted by section 4 of this title.

"Sec. 3. Imposition and Rate of Tax.—For the privilege of carrying on or engaging in any trade or business within the District and of receiving income from sources within the District, there is hereby levied for each taxable year a tax at the rate of 5 per centum upon the taxable income of every unincorporated business, whether domestic or foreign (except those expressly exempt under title II of this article)."

No exemption is afforded the practice of medicine under Title II of the Act.

"Title XIV—Licenses

"Sec. 1. Requirement.—No corporation or unincorporated business, except such corporations or unincorporated businesses as are expressly exempt under the provisions of title II of this article, shall engage in or carry on any trade or business in the District without a license so to do issued under this article in addition to all other licenses and permits required by law, except as hereinafter provided. For the first calendar year to which this article is applicable, no license shall be required of any corporation licenses under the provisions of the Act of July 26, 1939, as amended. Every corporation not so licensed and every unincorporated business shall obtain such license within sixty days after the approval of this Act. Every corporation or unincorporated business which commences to engage in or carry on any trade or business in the District after the passage of this Act shall obtain a license under this article within sixty days after the date of the commencement of such trade or business in the District. Applications for licenses shall be filed with the Assessor prior to January 1 of each year upon forms prescribed and furnished by the Assessor, and each application shall be accompanied by a fee of $10."

The answer to your questions will be found in the definition of the term "unincorporated business" contained in Section 1, Title VIII, Article I of the Act. Section 1 first states generally what is meant by the words "unincorporated business" and then reads as follows:

"The words 'unincorporated business' do not include any trade or business which by law, customs, or ethics cannot be incorporated or any trade or business in which more than 80 per centum of the gross income is derived from the personal services actually rendered by the individual or members of the partnership or other entity in the conducting or carrying on of any trade or business and in which capital is not a material income-producing factor."

It seems clear from the quoted language of Section 1 that the learned professions, which involve personal services and a confidential relationship between the parties are not "unincorporated businesses" within the meaning of the Revenue Act. Thus, it is not customary, is generally considered unethical and in many instances illegal, to incorporate the practice of medicine or law. The basic reason being that corporations cannot qualify to practice either medicine or law under the licensing laws controlling these professions. Furthermore, the corporate entity should not be permitted to come between the parties to the disruption of, detriment to or interference with the confidential relationships ordinarily involved in the learned professions.

Moreover the practice of medicine consists in the rendering of personal services and certainly more than eighty per cent of the gross income of physicians, whether they practice singularly or in concert with others, is derived from such personal services and capital investment is not a material income-producing factor.

In view of the provisions of Section 1, Title VIII, Article I of the Revenue Act, it is my opinion that the practice of medicine is not an "unincorporated business" within the meaning of those words as defined in the Act. Therefore, it may generally be said that medical practices require no license under Section 1, Title VIII, Article I of the Act.

You have asked whether or not the practices of doctors, who have become specialists in certain fields and have set up laboratories to render special medical services, which utilize, as well as the doctors involved, technicians, nurses and other help, would constitute unincorporated businesses requiring licenses and the payment of unincorporated business taxes under the Revenue Act. As I understand the facts to be in such situations, the doctors involved are still engaged in the practice of medicine and are merely rendering to the patients and to the profession specialized medical services requiring a high degree of skill and training. Personal service is still the basic income-producing factor as distinguished from capital investment earnings.

In my view, this method of practicing medicine does not subject the doctors involved to licensing under Title XIV, Article I or to the payment of the tax under Title VIII, Article I of the Revenue Act. There are many reasons in my opinion to support this view. Certainly it is not customary to incorporate such "trade or business." I use the words "trade or business" as they are defined in Paragraph H. Section 4, Title I, Article 1 of the Revenue Act, which states that these words include any "profession, vocation or calling" and do not thereby mean to infer that medicine is a trade. It is my understanding that more than eighty per centum of the gross income derived from such activities is derived from the personal services of the individuals involved. It is also to be noted that the "business" of such physicians is not a business in which capital is a material income-producing factor. The income-producing factor involved necessarily is the rendition of personal services and not the capital investment.

For these reasons I reiterate my opinion that such a medical practice need not be licensed and is not subject to an unincorporated business tax under the Revenue Act.

I trust that this letter is responsive to your inquiry.

Yours very truly,

Warren E. Magee
Legal Counsel to the
Medical Society of the
District of Columbia

BOOK REVIEW

The Years After 50. Wingate M. Johnson, M.D., Professor of Clinical Medicine and Chief of Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College, with a Foreword by Morris Fishbein, M.D., Editor, *Journal of the American Medical Association.* Price, $2.00. Pp. 147. New York: McGraw-Hill, 1947.

Never has so much sound medical information been available to the reading public as at present. Through the medium of books, magazines and pamphlets, the American people are told the causes of disease, its prevention and, to the extent that a layman can comprehend, its treatment.

There are still differences of opinion among medical men with respect to attempts to enlighten the laity in regard to health matters. Many of them feel that it only serves to make people overly solicitous of their physical well-being. However, a majority of physicians, it appears, are convinced that the benefits which result far outweigh the harm done. Neurosis may afflict a few because of what they read, but that is not the general rule. In fact, because they are enlightened, they are less fearful of disease and better able to cope with it.

The qualifications and the approach of writers on health subjects, of course, vary considerably. Among a select group who speak with authority and insight is Dr. Wingate M. Johnson of North Carolina. Physician, author, editor and educator, Dr. Johnson is splendidly equipped to write for lay consumption. His most recent contribution is a charming, informative little volume, "The Years After 50." Having passed the half-century mark himself, he displays a sympathy for and an understanding of the aging patient. Many passages in this book reveal Dr. Wingate for what he is—a kindly, humane and conscientious physician.

There is a warmth in this modest volume which is missing from most books of its kind. It is unhesitatingly recommended to individuals seeking common sense advice, not only in the matter of organic ailments, but in the equally important matter of meeting the emotional problems of later years. Doctors would do well to recommend this book to their patients.

T. W.

Epilepsy—Stevens

(*Continued from page 541*)

should be advised to inform the prospective mate of his illness. Epilepsy is no contraindication to sexual congress, but psychomotor seizures would militate against a happy relationship. If the male patient is physically incapacitated by his illness, financial problems might impose a further burden on his wife and he should be advised against matrimony. Enforced childlessness may produce psychologic reverberations with which the physician may have to deal, and again the question of parenthood can be decided only by the patient. However, under certain conditions the physician can feel justified in advising against parenthood.

According to Putman there are three sets of circumstances, any of which may be considered definite grounds for advising a given person not to have children. The first is the existence of a high degree of disability resulting from this disorder. The second is a history of convulsions occurring in 2 or more successive generations of his or her ancestors. The third is evidence that there is some tendency to seizures in the family of the other partner. Under any of these circumstances the likelihood that the children will be subject to seizures has been shown to be extremely high.

Other complex personal problems related to the patient's illness will be brought to the physician, who will find no two cases identical but who will find the treatment of epilepsy a gratifying experience as long as the chief concern of therapeutics remains the epileptic patient and not his disease.

MEDICAL SOCIETIES WITH LIMITED MEMBERSHIP

WASHINGTON, D. C.

1947–1948

SOCIETY	PRESIDENT	SECRETARY	NO. MEETINGS PER YEAR	DATE OF MEETINGS	PLACE OF MEETINGS
Baltimore-Washington Dermatological	M. Sullivan, Baltimore	L. B. McCaleb, Washington	8	3rd Thursday	Alternating Cities
Clinico-Pathological	J. Minor	T. J. Abernethy	8	3rd Tuesday	
Georgetown Clinical	T. F. Keliher	S. W. Hawken	7	3rd Tuesday	Hotel Statler
Georgetown University Medical Alumni Club	C. E. McNamara	G. H. McAteer	3	On call	
George Washington University	C. P. Reeves	O. B. Hunter	7	3rd Saturday	School of Medicine
Hippocrates-Galen	H. Carter	R. M. Caulk	5	On call	
International Medical Club	G. C. Ruhland	F. A. J. Geier	4	On call	
Jacobi	S. Dodek	L. Gerber	8	3rd Monday	
Kober	G. V. Simpson	W. R. Morris	8	3rd Monday	
Mackall	W. Atkinson	J. L. Thompson	8	3rd Thursday	
Medical Arts	J. A. Reisinger	T. F. Williams	8	2nd Thursday	
Osler	W. Atkinson	H. A. Grennan	8	3rd Monday	
Pan American (D. C. Branch)	A. B. Coulter	P. F. Dickens	4	On call	Roger-Smith Hotel
Physician-Veterans of World War II	W. Atkinson	O. B. Hunter, Jr.		On call	
Rheumatism	D. C. Crain	M. C. Cobey	3	On call	Medical Society Building
Saint Elizabeths Hospital	E. D. Griffin	M. Kleinerman	3	On call	St. Elizabeths Hospital
Washington Academy of Medicine	J. F. Siler	E. C. Albritton	3	On call	Roger-Smith Hotel
Washington Academy of Surgery	C. D. Briggs	L. B. Gaffney	4	2nd Friday Oct., Nov., Dec., Apr.	Mayflower Hotel
Washington Diabetes Association, Inc.	J. A. Reed	J. R. Veal	4	On call	
Washington Gynecological	W. J. Cusack	H. P. Ramsey	5	4th Saturday Oct., Nov., Jan., Mar., May	
Washington Heart	F. S. Horvath	B. J. Walsh	8	Last Friday	Assn. Hdqrs.
Washington Medical and Surgical	N. C. Shoemaker	J. F. Belair	6	4th Monday	Hotel Statler
Washington Ophthalmological	E. J. Cummings	J. T. Schnebly	4	1st Monday Nov., Jan., Mar., May	Medical Society Building
Washington Orthopedic Club	F. M. Hand	M. Mendelsohn	7	2nd Monday	
Washington Psychoanalytic	R. T. Morse	R. Buxton	8	2nd Saturday	Medical Society Building
Washington Society for Advancement of Psychotherapy	L. S. London	B. Karpman	8	3rd Thursday	
Washington Society of Pathologists	O. B. Hunter, Jr.	H. L. Stewart	7	1st Saturday	Army Institute of Pathology
Washington Urological	H. A. Fowler	C. E. Bagley	7	Every 6 weeks	
Women's Medical	K. E. Parker	C. L. Fusfeld	8	1st Tuesday	

NOTE: Most of these societies begin their regular meetings in October and continue through April or May. The Editorial Board would appreciate information regarding any additional medical societies not shown on this list.

Pollen Counts in Hay Fever—Seltzer

(*Continued from page 542*)

patient, and this should take into consideration the patient's individual pollen exposure, as well as related allergic factors such as dusts, epidermals, foods, general physical condition, etc., all of which are not revealed by the daily "pollen count." Careful observations of a large number of patients in this allergy clinic, where acute flare-ups were evaluated against the daily pollen counts, revealed that most of the time these exacerbations had no relationship to the pollen count, but could be explained on variations of the individual allergic load. It is important for the physician to attempt to discover the variations in his patient's allergic load rather than to shrug his shoulders and put all of the blame on the "pollen count."

These faults of the gravity pollen counts do not detract from its sphere of usefulness, as, for example, to give a standard base line to compare the relative severities of different seasons, or to provide a standard for comparison of the effect of drugs or eradication procedures, or to be used for intercity comparisons, etc. However, although the "pollen count" has importance for the statistical evaluation of numbers of allergic patients, it has much less significance for the individual patient.

BIBLIOGRAPHY

1. Feinberg, S. M.: Allergy in Practice. Chicago: Yr. Bk. Pub., 1946.
2 Wodehouse, R. P.: Pollen Grains: Their Structure, Identification and Significance in Science and Medicine. New York: McGraw-Hill, 1935.
3. Coca, A. F., Walzer, M., and Thommen, A. A.: Asthma and Hay Fever in Theory and Practice. Springfield, Ill.: Thomas, 1931.
4. Walzer, M. Durham, O. C., Black, J. H., and Glaser, J.: Preliminary report of National Pollen Survey Committee of American Academy of Allergy on proposed standardization of pollen counting technics. J. Allergy, 1946, **17**, 178.
5. Durham, O. C.: Volumetric indicence of atmospheric allergens; spot testing in evaluation of species. Ibid., 1947, **18**, 231.

2025 Eye Street, N.W.

Physicians Support Medical Service—Observer

(*Continued from page 572*)

If there is the response expected, and there is no reason to believe there will not be, Group Hospitalization, Inc. will have been notified sometime in October that the required number of physicians have signed their contracts and that the organization can proceed with enrolling of subscribers. T.W.

Washington Physicians of Yesterday—Stone

(*Continued from page 582*)

immediately recognized as a leader in his field, and where for the remainder of his life he specialized in gynecological surgery, attaining high standing in the profession and the community. He served as surgeon to Columbia Hospital for Women, in Washington, 1891–1921; also Georgetown University Hospital. He was Professor of Gynecology at Georgetown University School of Medicine, 1891–1921.

Dr. Stone was a member of very many medical societies. Among them were the British Gynecological Society, 1888–1935, of which he was a life member; the Southern Surgical and Gynecological Association—one of its ten founders in 1888, its Vice President in 1905, and President in 1918; the Medical Society of the District of Columbia from 1892; American Gynecological Society, 1898–1935; Washington Obstetrical and Gynecological Society; founder and member of the American College of Surgeons, 1913–1935; and Fellow of the Royal Medical Society of London, 1919–1935. He was a member of the Virginia Board of Examiners for Licensure, 1885–1888, of the Cosmos Club, 1898–1935; and an includee of "Who's Who in America." He was a very prolific contributor to medical literature, his bibliography listing no less than 198 titles.

In 1921, after fifty years of medical practice, Dr. Stone resigned his connections with the Columbia Hospital for Women and the Georgetown University Medical School. A few years later he retired altogether from active practice; and he died December 22, 1935.

During his attendance at the gynecological clinics in England in 1888 Dr. Stone acquired the then new technics of Listerian antiseptic surgery. That was a key which opened up a wide extension of surgical practice; and with the advances in that field he kept up in the forefront, and he made his own contributions for the improvement of the science and art of gynecology. He was a skillful surgical operator, with marvelous digital dexterity. He had an engaging personality, and won the confidence and esteem of his colleagues.

John B. Nichols, M.D.

MEDICAL ANNALS
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THE CLINICAL SIGNIFICANCE OF GAS SHADOWS IN X-RAY EXAMINATIONS OF COMPOUND WOUNDS*

EUGENE J. McDONALD, M.D.
Washington

AT A large general military hospital 146 casualties from a single severe explosion were observed. Most of them had X-ray examinations, and 21 of these patients who had compound wounds showed evidence of gas shadows in the soft tissues. In this paper an attempt will be made to explain the significance of gas shadows in compound wounds, especially those in which the amount of gas increases in extent following the first X-ray examination.

Bacteriology of Gas-Forming Organisms

Newer bacteriologic names have replaced what were formerly called "gas formers." The genus Clostridium includes a large number of spore-forming, anaerobic, rod-shaped bacteria.[1] Many of these are saprophytes, occurring in the soil, decaying animal and vegetable matter, and in the intestines of man and animal. Certain species, because of their ability to produce toxins, are important from a medical point of view. These include Cl. botulinum, Cl. tetani, and a group of organisms associated with the production of gas gangrene in wounds. The best known of this last group is Cl. perfringens (formerly called welchii). Others of this same group include Cl. novyi (formerly called oedematiens) and Cl. septicum (formerly called vibrion septique).

Most laboratory books mention only about a dozen of the more common pathogenic types. However, it is not unusual to be unable to classify strictly even the more harmful of these clostridia. Besides the pathogens there are almost innumerable saprophytic and other harmless variations within the genus. All of them produce gas to some degree and are universally widespread. Therefore, contamination is common.

Distribution and Pathogenicity of the Clostridia

The more important clostridia are widely distributed in soils and animal feces. Zeissler and Neller[2] (1927) found the following distribution in 200 European soil samples: Cl. welchii present in 100 per cent; Cl. novyi in 45 per cent; Cl. septicum in 8 per cent and Cl. histolyticum in 2 per cent. Pathogenicity of the anaerobes depends almost entirely on their toxic production. Cl. tetani, for instance, multiplies locally and does not invade the body. Cl. botulinum is not able to grow in the tissues at all. Its pathogenicity is due to the formation of a potent toxin in food prior to ingestion. Cl. novyi (oedematiens) remains almost confined to the site of inoculation. Cl. perfringens (welchii) and Cl. septique grow at the site of the wound, but they become truly invasive only when the death of the animal is near.

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* Submitted to the Executive Council, American Roentgen Ray Society, February 1, 1944, as thesis required for membership.

Clinical Aspects

MacLennan[3] states that the same pathogenic anaerobe can cause widely different conditions. Thus, Cl. perfringens may be found equally well in a healthy wound and a man dying from gas gangrene. On the other hand, organisms differing considerably in themselves can produce an identical picture, such as gas gangrene caused by Cl. novyi and Cl. bifermentas. Approximately 30 per cent of war wounds seen in the Middle East African Campaign were infected with the clostridia. Most of these contaminants were saprophytic, although some were pathogenic but not activated, because 1 or more of their special environmental conditions were lacking. Only 1.5 per cent of these war wounds containing clostridia were implicated as the cause of gas gangrene.

From these remarks it must be clear that the classification of anaerobic infections will have to be made on clinical grounds, and on this basis MacLennan[3] recognizes the following types of wound infections:

1. Simple contamination
2. Anaerobic cellulitis
3. Anaerobic myositis
    (a) Clostridial (gas gangrene)
    (b) Streptococcal
4. Postoperative synergistic gangrene
5. Fusospirochetal infection
6. Tetanus

Only the first three groups will be discussed, since they are the most interesting from a radiologic point of view.

Simple contamination. In the battlefields of Western Europe simple surface contamination was to all intents a certainty, and any but the most trivial wound contained clostridia. In most of these cases the presence of any of the anaerobes was quite unsuspected. In the vast majority of such wounds they were undoubtedly proliferating and could be recognized in stained smears. All varieties of clostridia have been found, both pathogenic and nonpathogenic. The predominating flora in these simple contaminated wounds produced no observable clinical changes.

Unless there is gross infection with the pyogenic cocci, the anaerobes as a rule disappear rapidly from the wound. In no instance is there any real invasion of the wounds by these organisms. They are proliferating in dead material within the wound, in necrotic muscle and cellular tissue, blood clot, and even in pus.

Anaerobic cellulitis. In about 5 per cent of these contaminated wounds the above described process of simple contamination advances a little farther. The anaerobic bacteria multiply in the necrotic debris in the depths of wounds and find conditions to their limited and peculiar needs. The muscles are not involved. It is true that in some cases clostridia may be demonstrated in muscular tissue, but this is dead muscle, already killed by trauma or vascular damage.

The anaerobes continue to multiply and spread in the cellular connective tissue, however, and as they grow they produce gas both by proteolytic and saccharolytic enzymes. This gas escapes into the tissue spaces, opens them up, and still further aids the diffusion of the organisms. Although these may not be strictly pathogenic in that they do not necessarily belong to the small group of toxigenic clostridia, they nonetheless produce a very definite clinical picture.

If gas is abundant, extensive, and easily demonstrable and there is no pronounced toxemia, the condition is almost certainly not gas gangrene.

Anaerobic myostis (*classical gas gangrene*). In about 1.5 per cent of wounds containing anaerobes and perhaps 0.4 per cent of all wounds infection is not limited to the tissues and necrotic debris. All the related tissues are invaded, usually with appalling rapidity, and, most important of all, muscle is involved. Nearly always the etiology is infection by the clostridia. In a very small percentage of cases only anaerobic cocci are to be found. These latter will not be considered in this paper.

This condition differs from those already described in two important features. It is essentially an infection of living muscle and 1 or more of the toxigenic clostridia are always involved. Anaerobic myositis is the usual condition obtaining when fulminating gas infection strikes.

Why in some wounds these organisms remain as harmless saprophytes, whereas in others they suddenly develop the most invasive powers, is a complex problem not entirely understood.

This disease is a clinical concept which has usually been recognized by the appearance of the patient and his lesion in its obvious and far advanced and often irreversible stages.[4] There are several predisposing factors which contribute to the severity or progress of the infection. Muscular areas, such as the buttock, thigh and calf, are more susceptible than the scalp, back or thorax.[5] It is a condition seen much more often in a male at the active period of life when he is commonly exposed to physical hazards. Reduction in physical resistance will similarly increase the incidence. Other factors which may play a part are the extent of devitalization of tissues, presence of foreign bodies, interference with blood supply, and delay in treatment.

VALUE OF ROENTGENOGRAMS IN DIAGNOSIS

From the foregoing discussion of the bacteriology, pathogenicity, distribution and clinical aspects of clostridial infection a consideration of the significance of finding X-ray evidence of gas in the soft tissues is suggested. It is regrettable but true that a diagnosis of gas infection or gas gangrene has in the past been made on the basis of 1 or 2 films that showed gas bubbles within the soft tissues.[6]

At a general hospital of well over a thousand beds, we saw from 1 explosion 146 patients, most of whom were X-rayed within 24 hours. Twenty-one of these patients showed gas in the soft tissues, many at the site of a penetrating wound, although many also showed gas shadows much removed from the area of the compound wound.

One patient died on the seventh hospital day. His films showed a large amount of air in the soft tissues of the right thigh, secondary to a fracture from a penetrating metallic fragment. Autopsy studies showed unidentifiable clostridia at the fracture site. Clinically gas infection was present in the soft tissues at the fracture site. However, death was not attributed to "gas bacillus infection" by the pathologist. In all probability, if the multiple wounds and shock had not been present, his natural bodily immunity could have taken care of the secondary infection at the site of the compound fracture. It is likely that the unidentified clostridium was either a saprophyte or one of low virulence, since he showed the gas in the soft tissues from the time of the injury to his demise. Certainly, his case did not even remotely resemble the classical fulminating, spreading gas infection.

In this catastrophe no cases of "gas gangrene" were seen and no pathogenic clostridia were recovered from the wounds, even though many cases showed X-ray evidence and gave the clinical impression of gaseous crepitation in soft tissues. Many patients were given "gas gangrene serum" and sulfonamides. There were 75 compound fractures from the same accident. Roughly one fifth to one sixth of the patients showed air pockets for several days after the explosion. Our great difficulty in thorough study in the past has been the immediate application of plaster casts which obscure many of these small gas shadows. Because of the war-stimulated enthusiasm for external fixation by the Haynes and Stader types of pins, plaster is used less, and it is hoped that radiologists will be able to substantiate our impression that air is much more common than formerly supposed and that the presence of air is not always the grave complication feared in the past.

One question which remains unsettled is the apparent discrepancy between our low incidence of bacteriologically positive pathogenic clostridia and MacLennan's high figures[3] from the Middle East. MacLennan obtained bacteriologic evidence of pathogenic clostridia in 20 to 30 per cent of his cases at some time, and yet gas gangrene developed in only about 1.5 per cent of these wounds. We were not able to get laboratory evidence of any type of clostridia contamination or infection in anywhere similar proportion. This difference may be due to either lower incidence of clostridia in the ground in the area of the explosion (which seems possible) or earlier hospitalization and aseptic precautions taken under the controlled sterile conditions obtaining in a hospital operating suite.

It appears that the final diagnosis must depend mainly on the clinical findings. Confirmatory evidence will be contributed by serial films taken over the course of 24 to 36 hours and bacteriologic evidence of pathogenic clostridia. Probably neither of the latter methods should be relied on completely.

CONCLUSIONS

Many cases of compound wounds have been seen to present roentgenologic evidence of gas shadows in the soft tissues for periods up to 3 days following injury.

Gas shadows in soft tissues can be produced (1) by the introduction of air with a foreign body, (2) by enclosing air at the operative closure of skin flaps, and (3) by the anaerobic clostridia.

The genus Clostridium comprises a very large group of spore-forming anaerobes. By far the larger number of these are saprophytes and nonpathogenic to man. Only a very few produce toxins of interest to us.

The significance of gas in a wound has been grossly exaggerated, and it is felt that not infrequently amputations or reamputations have been done on the basis of visualization of gas shadows in a wound or stump. Apparently these shadows are very seldom due to pathogenic clostridia. In the series presented there was not a single case of proven infection by pathogenic anaerobes in 15 months despite the volume of work and frequency of compound wounds.

At present a roentgenologic differential diagnosis between a pathogenic and a saprophytic gas-forming bacterium cannot be offered except that the presence of "air" visualized by X-rays in the first several hours is more likely to be mechanical. Its rapid extension and linear spread in the muscle planes suggest pathogenic infection.

It is felt that the vast majority of so-called "gas infections" with evidence of gas shadows in roentgenograms probably represent benign saprophytic or nonpathogenic contamination and that the patients would recover in the ordinary course of events regardless of the therapeutic use of roentgen rays, gas serum or possibly even sulfonamides.

As a corollary to these studies it would appear that the basis of roentgen treatment of "gas gangrene"[2] may rest on untenable grounds. Too often the mere presence of clostridia, even pathogenic, has been taken to prove the imminence of a fulminating gas infection. However, it has been shown that clostridial contamination occurs in 20 to 30 per cent of war wounds in MacLennan's series and yet only 0.4 per cent of all wounds develop gas gangrene. In addition, about 15 per cent of all compound wounds show X-ray evidence of gas in the soft tissues which by follow-up appear to be benign and do not represent true gas infection.

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A CLINICAL EVALUATION OF THE NEWER LIVER FUNCTION TESTS[*][†]

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DURING the past decade there has been a pronounced increase of interest by the clinician in the field of diseases of the liver. Undoubtedly, the great wealth of recently accumulated experimental data, as well as the occurrence of large numbers of cases of liver disease in the armed forces, have contributed materially to this renewal of interest. As a result, there has again occurred a search for a single liver function test which will satisfy all the necessary requirements. It will be our purpose in this discussion briefly to review the field of liver function and to evaluate the more recently developed function tests.

The liver, the largest gland within the body, is by far the most complex and highly specialized of all the glands of the body. Its described functions vary anywhere from 20 odd to some 60 or 70 and include metabolic activities, detoxification, hematopoietic processes, and reticulo-endothelial and certain secretory functions. This multiplicity and complexity of functions marks the first limitation in value of all liver function tests. All activities of this organ are not affected to the same degree by any specific pathologic process. Mann[1] has used the term "dissociation of the functional activities of the liver" to describe the variance in the functions of the liver in health and disease. By this expression he implies that all functions of the liver proceed more or less independently of the others and that marked impairment in one function can very well go along with normal activity in another function. Because of this multiplicity of functions the liver is much more a dynamic organ than a static one, and function tests may give varying results from day to day. Hence, minor degrees of abnormality of these tests must be interpreted very cautiously.

A second important factor limiting the value of liver function tests is the remarkable regenerative power of the liver. In experimental animals as much as seven eighths of the liver has been removed, only to be followed by restoration to normal size and weight in a short time. Clinically, simultaneous regenerative processes may compensate for and completely mask this damage, at least as judged by liver function tests.

Closely allied to the regenerative power of the liver is the great reserve power or margin of safety that exists in this organ. How much of this reserve must be destroyed before abnormal results are obtained with function tests is unknown. In 1931, using the tests in vogue at that time, Bollman and Mann[2] demonstrated that as much as 80 per cent of the liver could be removed before abnormal results were obtained with the liver function tests. Although the tests in use at the present are much more sensitive than those in use in 1931, this factor of safety makes it extremely difficult to develop an accurate quantitative liver function test.

Aside from the purely physiologic limitations which resulted in the abuse of liver function tests is the more practical question of the inadequate use and interpretation of these tests. Any test, whether it be a simple urinalysis or a complex blood determination for ketosteroids, merely measures one physiologic normal and hence necessarily answers only one question. As such the test does not make the diagnosis but merely adds another fact to the information available for the clinical evaluation. In disease of the liver, using one test of liver function is far worse than using none. How can one test be relied upon as a measure of liver dysfunction when the liver has so many different types of functions? Would it not be wiser, in view of the known physiologic and chemical activities of the liver, to use a combination of function tests so as to obtain a more integrated and balanced picture of the function of the liver? Would not the clinician be wiser if he selected a few tests, learned them and their shortcomings sufficiently well to be able to use them intelligently when the indication arose, instead of ordering haphazardly a liver function test and using that result in his diagnostic evaluation? Hoffbauer and his group[3] have recently pointed out the value of such composite liver function studies. They have even gone one step further and set their results up in graph form or profile. They intimate that the use of such profiles may eventually set up patterns to provide information both as to anatomic type of disease and prognosis.

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Faulty interpretation of liver function studies has also added to the confusion concerning their value as diagnostic aids. A test designed to determine the degree of hepatic insufficiency should not be used where one is attempting to ascertain the patency of the hepatobiliary tree. A test whose value is limited to the early stages of liver disease should not be utilized in a case of far advanced liver disease. In this connection it should be stated that at this time there is no one test which will accurately differentiate between a surgical obstructive jaundice and a nonsurgical intrahepatic jaundice. Unfortunately, too many liver function tests have been used along these lines and, of course, have been found to be inadequate and have of necessity been thrown into disrepute.

Not a single test, but a group of tests properly selected, used and interpreted by the clinician, can reliably assist in the differentiation of surgical and hepatic jaundice. In this category may be included quantitative and qualitative determination of urobilinogen in urine and feces, quantitative determination of serum bilirubin, duodenobiliary drainage, cholesterol partition in plasma, and phosphatase activity of blood serum. Diagnostic radiographic procedures such as cholecystography and hepatosplenography may also be of value in carefully selected cases. Similarly, a well chosen group of liver function tests can be used to estimate the extent of hepatic insufficiency. In addition, judicious repetition of these same tests can be utilized as helpful guides in the pre- and postoperative care and medical management of patients with hepatobiliary disease. In this category may be included the bromsulfalein test, hippuric acid synthesis, blood-serum protein level and ratio, cephalin flocculation test, and blood prothrombin level with its response to the administration of vitamin K.

With these general considerations relative to the use of liver function tests in mind, let us now examine some of the more recently developed tests of liver function to see wherein they may be of value to us in the diagnosis of hepatobiliary disease.

CEPHALIN CHOLESTEROL FLOCCULATION TEST

Of all the newer liver function tests, the cephalin cholesterol flocculation test of Hanger,[4] developed in 1938, has probably stimulated more interest and enthusiasm than any other. As originally described, it consists of adding the patient's serum to a colloidal suspension of cephalin cholesterol and observing for subsequent flocculation. The test is read in terms of plus signs, a 4 plus reaction indicating complete precipitation and flocculation of the lipid emulsion. In discussing his test, Hanger stated that "flocculation was consistently absent in all normal cases, but occurred in most instances when active disease was present." He further indicated that the test paralleled the clinical course of the disease, being most positive during the acute stages and gradually becoming less positive as improvement took place. In another publication the following year, Hanger[5] was able to substantiate these results, indicating that this test was the most sensitive of all function tests in use and, furthermore, that it was a valuable aid in the differential diagnosis of obstructive jaundice, since it remained negative even in long-standing extrahepatic obstruction. From this rather auspicious beginning, this test has had an up-and-down course in medical literature. Pohle and Stewart[6] were able to substantiate Hanger's claims for the test but were unable to validate its use as an aid in the differentiation between obstructive and hepatogenous jaundice. Rosenberg and Soskin,[7] Mateer and his group[8] and I,[9] using comparative evaluation studies of liver function tests, were all in agreement that the cephalin flocculation test was the most sensitive of all liver function tests and gave a higher incidence of positive results than any other test used. Wade and Richman,[10] in a recent communication, likewise confirmed the sensitivity of this test but could not ascribe any value to the test as a means of differentiation between obstructive and hepatogenous jaundice. However, it was not very long before conflicting reports appeared concerning the use of this test. Different and varying results were reported, depending upon whether ripened or unripened cephalin was used. With the unripened cephalin the results were found to be inaccurate and variable. Sunlight was shown to have an effect on the outcome of this test, the reaction apparently being photosensitive and exposure to light resulting in false positives.[11,12] Indeed, recently, Moses[12] illustrated that exposure of even normal sera and cephalin to artificial light resulted in positive reactions, although pathologic sera did give in the main more positive results. He suggests that this test should be run in the light as well as in the dark for accurate results. To correlate all these various reports is difficult and practically impossible; just as with most other clinical laboratory procedures there are always differences of opinion.

In my estimation the cephalin cholesterol flocculation test remains today one of the most sensitive tests in the diagnosis of hepatic disorders. For best results it should be performed in the dark with ripened cephalin, plus-minus and 1-plus results being discarded as not significant. It is a simple test, requiring no special technics and capable of being performed in the average physician's office with a minimum of difficulty. It is not a measure of liver function, in the sense that it measures hepatic reserve or insufficiency. It merely indicates the degree of activity of a pathologic process within the liver or the absence or presence of such an active process. It does not measure the degree of impairment of hepatic function and as such has no correlation with the other tests of liver function. Thus, it is perfectly possible to have a negative cephalin flocculation test with a markedly abnormal hippuric acid excretion test, such as might occur in an old but inactive case of cirrhosis of the liver.

This test serves its main usefulness as a guide to diagnosis, therapy, and prognosis in cases of hepatitis. Taken in conjunction with other tests of hepatobiliary functions, it has only limited value in the differential diagnosis of intrahepatic and surgical obstructive jaundice, and then only when used in the early stages of the disease. One of the favorable features of this test is that it can be used without any difficulty in the presence of jaundice.

Colloidal Gold Test

Very similar to the cephalin flocculation test is the colloidal gold test of hepatic function described by Gray[13] in 1940. In this test the blood serum in a series of dilutions is allowed to react with a solution of colloidal gold. After this mixture is allowed to stand for 12 to 24 hours the results are read from 5 to 0 as with other colloidal gold mixtures. Five indicates complete precipitation of the gold and 0, of course, no precipitation. In each test 3 tubes of the patient's serum of a known dilution are mixed with 5 c.c. of colloidal gold. Any result which starts with a 5, denoting complete precipitation, such as 542, 552, or 522, is considered a positive test, whereas any reading starting with any number below 5 is a negative test.

As originally reported, this test was found to be very sensitive, giving positive results in 89 out of 96 cases of known liver involvement. As a test of liver function it has little to recommend it for routine use except its high degree of sensitivity. The technical details associated with the preparation, standardization and acidification of the colloidal gold solution are so complicated and time-consuming as to make the test very undesirable for even the well equipped and operated laboratory. Its use should be definitely limited to the research laboratory, where variance of the colloidal gold solution can be properly controlled in order to avoid false positive reactions.

Thymol Turbidity Test

The newest of the tests using the principle of the cephalin flocculation and colloidal gold tests is the thymol turbidity test of Maclagan[14] described in 1944. In this test, 60 volumes of a prepared and buffered solution of thymol is mixed with 1 volume of serum and allowed to stand for 30 minutes. The resulting turbid solution is then compared in a comparator with turbidity standards. The results are recorded in arbitrary units equal to the appropriate standard divided by 10, additional allowance for dilution being made if necessary. Normal serum gives values from 0 to 4. In positive tests, flocculation frequently occurs on standing overnight, but this is not an essential part of the test. The test gives results that are comparable to those obtained with the cephalin flocculation test. The technics are very much the same with the exception that in the thymol turbidity test results are available in $\frac{1}{2}$ hour, instead of 48 hours as with the Hanger test.

Experience with this test has been too limited at this time to determine its true value as a liver function test. Like the cephalin flocculation test it appears to be a measure of the degree of activity of a disease process, rather than a quantitative estimation of the degree of hepatic insufficiency. It differs from the cephalin test in that the questions of proper aging of reagents and photosensitivity do not have to be taken into consideration. One of the difficult features of the test is the proper maintenance of the turbidity standards. These are rather difficult to obtain and somewhat unstable, requiring frequent adjustments and corrections. Final evaluation of this test must await additional clinical trial, but from present indication it would seem that it brings nothing new to the field of liver function testing.

In the 3 tests just described, the fundamental mechanism appears to be a reaction between the testing material and some one of the protein constituents of the patient's serum. In his original papers, Hanger[4,5] suggested that the test depended upon the presence of an abnormal nitrogen-bearing constituent in the globulin fraction, presumably produced by the diseased liver. This abnormal globulin becomes attached to the surface of the cephalin cholesterol particles and because of ensuing changes in surface potential, flocculation occurs. In describing the possible mechanism of the colloidal gold test, Gray[13] stated that the reaction might depend on a qualitative rather than a quantitative variation in the plasma globulin and that the euglobulin might be an important factor in the reaction. In the thymol turbidity test, it is also believed that the reacting substance with the thymol buffer is the gamma globulin of the serum. The similarity in the theoretical mechanisms of these tests would suggest some relationship, perhaps, between liver dysfunction and protein metabolism and synthesis. Kabat and others,[15] using electrophoretic protein dissociation, have shown that the cephalin flocculating activity of sera is definitely associated with the gamma globulin. They found this to be true regardless of whether the gamma globulin was derived from normal or pathologic sera. They further illustrated that the re activity of these gamma globulins could be inhibited by adding electrophoretically separated albumins. All such added albumins, however, do not show similar degrees of inhibition, a fact which indicates that the inhibition may not be due to the major component of the albumin but rather to some minor component migrating in the albumin fraction.

In studying cases of liver disease at this hospital I have found no correlation between the cephalin flocculation test and the globulin fraction or albumin-globulin ratio of the serum. It was noted, however, that in a statistically significant number of cases lower serum albumin levels were associated with a 4-plus cephalin flocculation reaction and that above the critical level of albumin of 4 grams per 100 c.c. there were no cases in which 4-plus cephalin tests were observed. This was more obvious in the chronic cases of liver disease than in the acute cases of liver disease. In spite of these suggestive findings, the nature of the factors in normal sera which prevent positive reactions, or the nature of the factors in pathologic sera which produce positive reactions with these tests is still unknown.

Bromsulfalein Test

This is not a new test, having been first described by Rosenthal and White[16] in 1924. Since its original introduction with a dose of 2 milligrams of the dye and the collection of blood specimens at 5 and 30 minutes following injection of the dye, there have been several modifications. The first major change was the introduction of the 5 milligram dose of the dye by MacDonald[17] in 1939. Following this, there was considerable disagreement by the workers in the field concerning the time interval which should elapse after the dye is given and before the blood is drawn. Both the 30-minute and 45-minute interval are strongly recommended.[18] On the basis of my experience, I would recommend the use of Mateer's technic[19] in which 1 specimen of blood is withdrawn 45 minutes after the dye is given.

This test has its major application as a measure of the degree of hepatic disease. It cannot be used when jaundice is present. In comparative studies with other tests, the 5 milligram test as described above has been shown to be just as sensitive as the cephalin flocculation test and the intravenous hippuric acid test. It is a simple test to perform, requiring no costly laboratory equipment, and gives reliable and uniform results. It is highly recommended for use by the general practitioner and internist for an estimation of the degree of liver insufficiency.

Intravenous Hippuric Acid Test

In 1938 Quick[20] introduced an intravenous hippuric acid liver function test, based on the same principle of the oral hippuric acid test, namely, the ability of the liver to conjugate benzoic acid and glycine to form hippuric acid. In the intravenous test, 1.77 grams of sodium benzoate dissolved in 20 c.c. of distilled water is injected slowly over a 5- to 10-minute period. The patient empties the bladder before the material is injected and again 1 hour after the completion of the injection. This urine specimen is then analyzed for hippuric acid. Normal adults excrete from 0.70 to 0.95 gram of benzoic acid as hippuric acid during this period of 1 hour. This modification has certain very definite and obvious advantages over the oral test. It does away with the nausea and vomiting that frequently accompany the oral test. By the administration of the sodium benzoate intravenously the danger of faulty and inadequate absorption is eradicated. It also decreases the duration of the test from 4 hours to 1 hour. More important to the clinician is the fact that this test is considerably more sensitive than the oral test and as such is capable of detecting liver damage much earlier. It is a simple test to perform, requiring no special apparatus or involved technics. It is a reliable test, in that the average individual can repeat the test with good correlative results.

I have found this test to be a valuable one in the testing of liver function. It is based on a metabolic and detoxifying mechanism of the liver and as such differs from the bromsulfalein test, which measures an excretory function of the liver. It is not quite as sensitive as the latter and definitely not nearly as sensitive as the cephalin test. It serves its greatest usefulness as a means of evaluation of hepatic insufficiency and can be used as a guide to the therapy and prognosis of hepatic disorders. It also can be used as a guide to the preoperative preparation of patients with cholecystic disease, especially in the presence of jaundice, which does not affect this test at all.

Prothrombin Time and the Response to Vitamin K Therapy

In 1941 Lord and Andrus[21] introduced the determination of the prothrombin time and its response to the parenteral administration of vitamin K as a means of testing liver function and differentiating between intra- and extrahepatic jaundice. The test is relatively simple to perform and consists of the withdrawal of blood for determination of plasma prothrombin and the immediate injection of 2 milligrams of Menadione intramuscularly. Twenty-four hours following the injection, the plasma prothrombin time is determined, and if there is any question regarding the results, determinations are again made at 48 and 72 hours. The prothrombin time is determined by the technic of Warner, Brinkhous and Smith.[22] If a rise of 10 per cent or more in the plasma prothrombin has occurred, the patient is considered to have extrahepatic disease with no liver damage. A rise of less than 10 per cent suggests intrahepatic disease, but determinations of the plasma prothrombin are repeated at 48 and 72 hours. If the rise then is less than 15 per cent over the initial level, the patient may be considered to have intrahepatic disease.

The test is based upon the well-founded relationship between plasma prothrombin and normal liver function. It has been repeatedly shown that removal of the liver is followed by a progressive fall of the plasma prothrombin. Within 14 hours after removal of the liver the plasma prothrombin is less than 10 per cent of normal. This test is based on an entirely different function of the liver than any of the ones previously mentioned. It is a direct and simple measure of a single and distinct metabolic function of the liver, namely, synthesis of prothrombin. It is a relatively easy test to perform, leaving very little chance for experimental errors. It is of particular value in helping to differentiate between intra- and extrahepatic jaundice, the presence of which does not affect the test at all. It is also of special help in determining the degree of liver damage in surgical operative conditions. If the prothrombin time is returned to normal by the administration of the Menadione, the liver is not damaged and the operative risk is good. However, if the administered vitamin K does not return the prothrombin to normal, the operative risk and mortality are bad. This test is very strongly advocated by Ivy,[23] who states that the determination of the prothrombin time and the response to vitamin K therapy is the most practical of all tests of liver function.

Summary

An attempt has been made to discuss briefly the complexities of liver functions with the resultant difficulties for any test of liver function. General considerations in the faulty interpretation and use of liver function tests have been

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UNNECESSARY SURGERY*

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BEFORE we can conclude when surgery is unnecessary we must first know when surgery is necessary. Surgery should be instituted to save life; to prolong life; to relieve symptoms, either physical or mental; for diagnosis; for prophylaxis. Furthermore, surgery should be instituted for the aforementioned reasons only if there is no other method available which is safer, better, or more economical, and even then, only if it does not substitute other symptoms which are worse than those to be relieved.

Certain of these criteria will meet with unanimity of opinion. For example, an acutely inflamed appendix should be removed to save life. A colostomy is indicated for the relief of an obstruction due to an inoperable cancer of the rectum to relieve symptoms and prolong life. A calculous gall bladder should be removed if it is the cause of colics. A lipoma, even though symptomless, may be removed to relieve the mind of a patient with cancerphobia. A tumor of the breast may be removed for study if there is suspicion that it may be malignant. A cervical polyp or rectal adenoma may be removed to prevent hemorrhage or possible malignant changes.

However, the conditions may not always be so clear-cut. There may be a divergence of opinion as to the treatment of certain diseases. This will depend on the experience of the individual physician, his predilections, his evaluation of end-results, or possibly his school of thought. Each may be able to muster authorities, statistics, and experiences to support his views. For example, one may wish to treat thrombosis and embolism by anticoagulants, another by vein ligation. One may prefer to treat hyperthyroidism by drugs, or by psychotherapy, and another may prefer surgery. One psychiatrist may treat certain depressions by psychoanalysis, another by shock treatment, and still another by psychosurgery. One orthopedist may insist on open reduction rather than closed reduction for certain types of fractures. Surgery performed for such cases is a matter of preference rather than being unnecessary.

In surgery, as in other fields of endeavor, time, experience, and new discoveries may change our viewpoint. Because of advances in technic, discovery of new or better drugs, criteria may change. Radiotherapy has displaced surgery in the treatment of tuberculous glands of the neck or carcinoma of the cervix. Chemotherapy has made surgical intervention unnecessary in some of the infections, and the reverse is also true. Certain diseases heretofore not amenable to surgery may now be attacked surgically. The lung, esophagus, pancreas, and the heart and great vessels are no longer outside the surgeon's domain. Again, added knowledge and experience may prove some procedures to have been ill-conceived or disappointing in late results, and these are abandoned. Colectomy is no longer done for auto-intoxication, plication for visceroptosis, suspension for every palpable kidney. Disappointment in late results often will lead to abandonment of conservative surgery for more radical surgery. Cholecystostomy has given way to cholecystectomy in cholelithiasis; abdominoperineal resection for posterior resection in carcinoma of the rectum; subtotal gastrectomy for gastroenterostomy in certain types of duodenal ulcer; total hysterectomy for supra-vaginal hysterectomy. These are only a few examples.

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If the above-mentioned criteria are acceptable, the obvious corollary is that any surgical procedure that does not satisfy these conditions is unnecessary. Assuming that any surgeon worthy of the name is capable and altruistic and, therefore, is conversant with the indications for surgery, why is unnecessary surgery performed? Certainly, you and I are unwilling to accept the canard bruited around by some psychiatrist that every surgeon is a sadist at heart. Can you imagine what would happen if a sadistic surgeon and a masochistic patient ever got together? Probably nothing worse than if a woman suffering from nymphomania were to meet with a man suffering from satyriasis. I am rather inclined to believe that unnecessary surgery is the result of improper diagnosis, lack of coördination or misinterpretation of objective and subjective symptoms, and finally lack of surgical judgment.

Improper diagnosis is due usually to haphazard, hurried examinations, undue stress and importance laid on laboratory findings, and atrophy of disuse of the five senses and occasionally the sixth sense, common sense. It is true that an improper diagnosis may be made even after thorough study and investigation. In our present state of incomplete knowledge of physiology and pathology it is quite easy to be mistaken. And paradoxical as it may seem, sometimes an operation performed because of a wrong diagnosis is not unnecessary.

In seeking the proper diagnosis time may be a factor. The emergency case must be approached differently from the elective case. In the emergency case the surgeon must ask himself three questions:

1. Is surgery advisable in any event, even if the diagnosis is not complete?
2. Is surgery unwise, but no great harm will ensue if it is done?
3. Is surgery contraindicated, and if performed may great harm follow?

In the first category, when surgery is advisable in any event, the exact diagnosis is not of sufficient importance if it entails delay. Here the decision to operate has been made and urgency is desirable. For example, a patient presents himself with a rigid abdomen, with the history, physical findings, and laboratory examinations that point to an acute surgical emergency. What difference does it make if the cause is a perforated ulcer, a perforated appendix, or a ruptured diverticulum?

In the second category surgery would be considered unwise, were the correct diagnosis known, but no great harm is done if surgery is performed. For example, the findings point to an acute appendicitis and operation discloses an acute mesenteric adenitis or even acute salpingitis. Here the surgeon chooses the lesser of two evils. For were the reverse true, and should an acute appendicitis be allowed to perforate in the mistaken idea that he was dealing with a mesenteric adenitis, his position would be untenable.

In the third category surgery is most definitely contraindicated and if done great harm may ensue. These are the cases the surgeon must carefully exclude. To operate for acute appendicitis and find that the patient has a central pneumonia, or typhoid fever, or scarlet fever, or impending diabetic coma, would be a grave error.

In the elective case there is less excuse for error. Here there is sufficient time to make a complete and thorough study. It would be entirely indefensible to perform a radical mastectomy for carcinoma of the breast and overlook the fact that the lungs are riddled with metastases. Nor would it be proper to do a craniotomy for a brain tumor and find that it is a metastatic lesion from a primary tumor of the lung. Consider the woman of about 40 who comes in complaining of lower abdominal pain and frequency and urgency of urination. Her menstrual history as given is quite normal. Examination discloses an irregular pelvic mass. To explore that pelvis without further ado would be entirely unjustifiable. The wiser surgeon will be most circumspect. He will disregard the menstrual history. Women with an unwanted pregnancy can be most misleading in giving their history. The urine can be subjected to a pregnancy test and even if it is negative reëxamination after a month's wait may be in order. And if there is still some question, a consultation with a highly respected and, preferably, older colleague will help divide the responsibility. To explore the pelvis for such a condition without due care would be bad enough. To fail to recognize a pregnancy, even if there were fibroids present, and do a hysterectomy would be calamitous. Even though one had accomplished exactly what that patient had intended, he should not be surprised to find her perverse enough to sue him for malpractice afterwards.

But even in the elective case it is not always possible to make an accurate diagnosis because our present knowledge is incomplete. For example, a painless jaundice may call for an exploration which may prove fruitless, but it can hardly be called unnecessary surgery. Prolonged, painless jaundice which cannot be explained is so serious that an exploration is justifiable in the hope that in an occasional case a common duct stone or some other condition amenable to surgery may be found and a life saved.

The second cause of unnecessary surgery is misinterpretation of symptoms. Here, too, there are two categories. In one category is the patient with definite symptoms and findings which can easily be attributed to an existing surgical condition but in reality is due to a medical condition. For example, a patient may have epigastric pain and show a calculous gall bladder, but his pain may be due in reality to coronary disease. Or one may complain of perineal pain, or pelvic pain, and on examination show internal hemorrhoids or uterine fibroids, yet the true cause of the pain may be bony pelvic metastases. A patient may complain of a rupture, and on examination show a bubonocele, but a herniotomy will be of little avail if the underlying difficulty is prostatic hypertrophy. Here is one condition amenable to surgery, and the underlying cause is overlooked because of another ailment which is also surgical, but is the effect rather than the cause. The same may be said of attempting to obliterate varicose veins without first checking the pelvis for a tumor which may be the basic cause of the varicosities.

In the second category, the subjective symptoms are many but the objective findings are few or insignificant. Here lies the bulk of unnecessary surgery. Weeding out the functional from the organic symptoms may tax the ingenuity of the most experienced and conscientious surgeon. Not every pain in the right lower quadrant is appendicitis. Chronic appendicitis, if you believe there is such a condition, is quite rare. Is this a true chronic recurring appendicitis, a sequel of previous mild acute attacks of appendicitis, or is it a case of a spastic colon due to emotional instability? Of course, a retroverted uterus may cause dysmenorrhea, backache, and even general malaise. But there are many, many more which are symptomless. It is an easy matter to see if a pessary will relieve the backache. Certainly, neither a pessary nor a suspension will cure obesity and weak feet, nor will it solve domestic infelicity, economic stress, or plain overwork. And even if the retroversion is the only cause of the complaint one should hesitate to offer a surgical remedy if more pregnancies are contemplated. Nor will a cholecystectomy done on the basis of a poorly functioning gallbladder disclosed by cholecystography cure dyspepsia caused by bad eating habits, bad chewing surfaces, or excessive smoking. Not every uterus with a bump calls for a hysterectomy. Not every fullness in the neck of a maturing girl is an indication for a thyroidectomy. Neither will cure either menopausal difficulties or a frustrated love affair. Every physician must be a psychologist and understand the emotional background of his patient. Careful history-taking and sympathetic understanding will obviate many an unnecessary operation. The patient's domestic and emotional life must be studied as well as his blood and excreta.

The third cause of unnecessary surgery is lack of surgical judgment. Just as it is important not to delay surgery when it is indicated, so is it just as important to know when to procrastinate. Waiting for certain infections to localize is good surgery. At times an operation may be avoided. Similarly, not all subphrenic inflammations will go on to suppuration. Choosing the propitious time for surgery is just as important as good technic. One case especially comes vividly to mind. I had operated on a member of a physician's family for a ruptured appendix. Despite her 230 pounds, with the help of sulfonamide therapy and the newly discovered penicillin she went on to an apparently uneventful convalescence and was ready to leave the hospital. But as very often happens to families of physicians, she began to run a spiking fever and complained of pain in the right upper abdomen and renal region. Both the patient and surgeon felt uncomfortable and, I might add, perspired freely. I began to look for the cause. The abdomen was soft and the pelvic examination failed to reveal anything unusual. There was tenderness over the right twelfth rib posteriorly, and the diaphragm was elevated on the roentgen-ray examination. Sulfonamides had been discontinued a few days previously, and the urine showed no crystalluria and was entirely negative. We knew the patient had a chronic cholecystitis, but this was not an acute cholecystitis because the abdomen was quite soft. The white blood cell count was in that anomalous position where it might mean anything. What was to be done? Was this a pylephlebitis with a liver abscess? Was this a subphrenic abscess? The penicillin was increased to 50,000 units and given every 6 hours in alternate buttocks with refrigeration to slow down absorption (the beeswax and oil was not available then). But when after a few days the fever continued unabated, we had about concluded to explore for a subphrenic abscess. That night I paid an unexpected visit to the hospital. I looked at my patient's chart and the 8 o'clock temperature was 103.6° F.; I walked slowly and lugubriously into the ward to see my patient. To my amazement she was having a hilarious time visiting with the other ward patients and at the same time was consuming a huge club sandwich which she had induced someone to buy for her on the outside. When I upbraided her she countered with the fact that she was starved and hadn't eaten for a week. I began to reconsider the whole matter. It seemed incongruous for a patient with a subphrenic abscess to feel so well. I decided to discontinue all medication, especially penicillin. The temperature dropped to normal in 24 hours and remained normal. We know now that penicillin may have febrile reactions.

Surgical judgment is also very important in knowing how much to do. Knowing when to stop is just as important as when to operate. Having performed a thyroidectomy for a toxic goiter it is unwise to add a tonsillectomy. A hysterectomy is sufficient unto itself without removing a gallbladder which may have stones. And it may be just enough to tip the scales against recovery if, after a difficult pelvic operation, an appendectomy is thrown in for good measure. The late Dr. C. H. Mayo used to say that there is many a grave in the cemetery because of bargain-counter surgery.

From what has been said it will be seen that it is not always easy to decide what is necessary and what is unnecessary, but it is well to remember that no surgery that is unnecessary is innocuous. Aside from adding insult to an already harassed mind, a patient using the operation as an escape will be the source of worry to the surgeon. Such a patient enjoys poor health and will make the most of it. Consider the many possibilities for any of a host of complications that beset the surgical patient. Wound infections, lung complications, accidents of anesthesia, phlebitis, and even embolism may

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EXTRAGENITAL CHANCRE

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INNOCENTLY acquired syphilis is not a great rarity. The primary lesion in such cases is usually extragenital. In a survey of the literature for the incidence of extragenital chancres, one finds that the most common site is on the lips, the incidence varying, according to various investigators, from the 48 per cent of Wile and Holman to the 77 per cent of Cole.

Chancres of the tongue have a less common incidence, but are second in frequency to those on the lips. In the transmission of the disease extragenitally the ordinary kiss is by far the most predominant method, and constitutes a real danger. Whether the kiss is merely the ordinary osculatory greeting or the kiss of love is purely of didactic interest. Other forms of sexual contact, such as cunnilingus and fellatio, are less common methods of transmission; and the least common method of contact is by means of intermediate objects, such as drinking cups, shaving brushes, etc. That the lips and tongue are the most frequent sites of extragenital chancres is easily understood when one considers that osculation is the most common means of close physical contact other than coitus. In addition, the lips and tongue offer an ideal situation for the entrance of the T. pallidum by virtue of frequent microscopic and macroscopic breaks in the surface epithelium. Many patients with chancres on the lip give a history of a preceding nonspecific lesion at the site of the chancre, such as a "cold sore," cigarette paper tears, burns, etc. Others give no history of preëxisting lesions, and no clue as to the method of transmission can be determined.

Since early in the disease the serologic test is frequently negative, these lesions present a real problem in diagnosis. They are frequently mistaken for and must be differentiated on the lips from epitheliomata, herpes labialis, and pyogenic granuloma; and they must be further differentiated from rarer lesions such as tuberculous chancre, chancroids, blastomycosis, and actinomycosis. On the tongue they should be differentiated from epitheliomata and "canker sores." In this area diagnosis is made more confusing by the difficulty of finding and differentiating T. pallidum on darkfield examination. It must also be borne in mind that a chancre may be superimposed on a preëxisting lesion of some other disease, particularly on an epithelioma and will, therefore, fail to heal under antisyphilitic therapy. Stokes formulates the idea that all lesions in or about the oral cavity which are indurated, slow to develop and heal, and are accompanied by satellite adenopathy, should be considered syphilitic unless proven otherwise.

In one of the cases reported here, the diagnosis presented considerable difficulty because of negative serology and negative darkfield examinations, and for a time the diagnosis of inoculation tuberculosis was seriously considered. It was only by repeated and persistent investigation with a coöperative patient that it was possible to establish a correct diagnosis. It is of further interest to note that the history in most cases of extragenital chancres is difficult to obtain. Because of the social aspect of the disease and its mode of transmission, patients are extremely reluctant to give accurate information. They are prone to abbreviate and camouflage many of the intimate details which help to determine the source of infection and the circumstances by which the disease was transmitted. Even though their infection may have been acquired innocently, most of them have sufficiently guilty consciences which compel them to hide information.

REPORT OF CASES

Case 1. A white female, 33 years of age and of sthenic habitus, presented, when first seen, 2 indurated, ulcerated lesions about 1 cm. in diameter on the opposing surfaces of both lips, at their centers. The lesions were of 4 weeks' duration. The one on the lower lip had appeared first and had slightly regressed in size over a period of about 2 weeks when the second lesion appeared on the upper lip. This second lesion grew and surpassed the first lesion in size. Both were painful and interfered with eating. Herpetic lesions had preceded the ulcer on the lower lip by 3 weeks. The regional lymph nodes were enlarged to the size of filberts. Repeated darkfield examinations, done daily for 3 successive days, were negative. After the second darkfield examination the submaxillary nodes became enlarged to the size of small plums and were exceedingly painful. The nodes of both sides were aspirated on 2 occasions and the material examined for T. pallidum. None were found, although careful search was made. Three serologic tests for syphilis were done during this time, all of which were negative. No cutaneous lesions were present other than those on the lips. A week later samples of blood still gave negative serologic tests for syphilis. The lesions had not regressed, and darkfield examinations done at this time were also negative. Two days later blood samples were sent to the Army Medical Center for further serologic study. Darkfield examination repeated at this time revealed no treponema. Results of the serologic study at this time were:

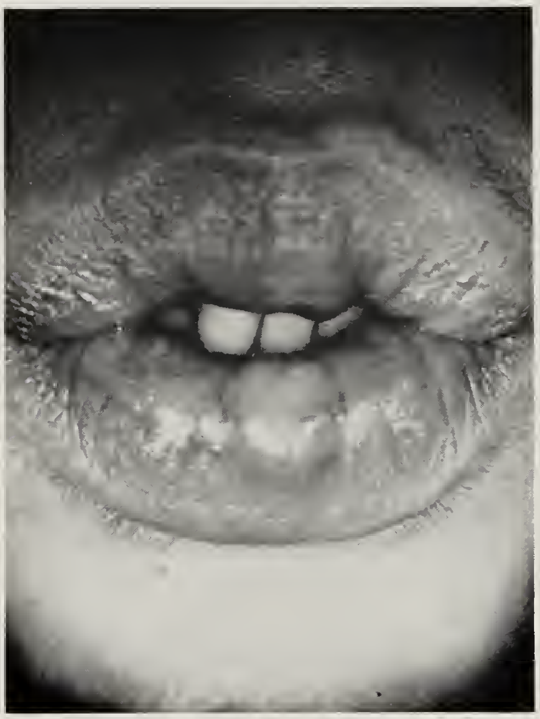

FIG. 1. Case 1. Scars at center of both lips. Photograph taken 1 year after chancres had healed.

Kline diagnostic	positive, 15 units
Kline exclusion	positive, 48 units
Cardiolipin slide	positive, 52 units
Mazzini	positive, 16 units
Kahn	444
Kolmer	4
Verification test	an inconclusive type of reaction

This was repeated in 2 days, with the following results:

Kline diagnostic	positive, 18 units
Kline exclusion	positive, 72 units
Cardiolipin slide	positive, 120 units
Kahn	444
Kolmer	4
Verification test	A reaction suggestive of syphilis.

These tests were considered to be diagnostic of syphilis and antisyphilitic therapy by means of combined penicillin, arsenic, and bismuth routine was administered. The lymphadenopathy disappeared in 4 days, and the lesions on the lips began to heal. In 8 days the lesions were completely epithelialized, but some residual induration remained for several months (fig. 1).

This patient was most coöperative in determining her contacts. She denied veneral contact per vaginum and per orum most emphatically but did confess of having kissed several men recently. One of the men, about 4 months before, while in Cuba, had complained of hoarseness which had lasted several months. His blood gave a strong serologic test for syphilis.

Case 2. This patient, a Venezuelan 32 years old, was a big league baseball player by profession. He was over 6 feet tall and a virtual Hercules. A thorough physical examination gave completely negative findings. There was no history of a penile or extragenital primary lesion or of secondaries. He denied sexual relations in any but the normal manner, although he admitted to frequent and indiscriminate coitus. The only positive finding was a history of a severe hoarseness. It began while he was in Cuba. He was treated by benzoin inhalations and various topical antiseptics. He admitted having kissed patient number 1, but denied emphatically and belligerently any other type of sexual contact. A specimen of his blood was divided in 2 parts. Half was sent to the public health laboratory, and the other half to a private laboratory. The findings were as follows:

Public Health Laboratory	positive
Private Laboratory	
Wassermann	acetone insolute antigen 4 plus cholesterinized antigen 4 plus
Kahn reaction	1 plus
Standard Kahn test	4 plus
Quantitative Kahn	200 Kahn units

He was completely uncoöperative and irresponsible and at the time of writing had gone back to Venezuela, taking his syphilis with him, leaving his common law wife and children completely unprovided for.

Case 3. The wife of patient number 2 appeared at my office complaining that she had had a sore on the tip of her tongue which lasted about 1 month and then slowly disappeared. The sore was not particularly painful but had made eating difficult and was generally uncomfortable. She was a young female of sthenic habitus apparently not acutely ill. A physical examination revealed a white depressed scar on the tip of her tongue and some palpable nodes in the submental region about the size of large peas. All other physical findings were essentially negative. She denied all sexual relationship other than per vaginum, but had frequently kissed her husband. She lived with her family, who believed that she was truly married to patient number 2. On the other hand, he maintained his own apartment which he shared with some other Venezuelans. No history of preëxisting nonspecific lesions at that site prior to the appearance of the chancre could be obtained. Her serology was as follows:

Wassermann reaction	
Acetone insoluble antigen	4 plus
Cholesterized antigen	4 plus
Kahn reaction	
Standard Kahn	4 plus
Presumptive Kahn	4 plus

One week later this was repeated with the same results and a quantitative Kahn revealed 200 Kahn units. She was started on a regimé of semi-rapid bismuth and arsenic therapy. After 2 weeks she ceased taking treatment although she realized the seriousness of the disease. Follow-up measures to get her to resume treatment were futile. She had 2 male children under 4 years of age who were the sons of patient number 2. These were healthy and strong, resembling their father in physical structure. All physical findings were negative, and repeated serology on both of these children yielded negative findings.

Case 4. A Negro male aged 43 presented a large indurated tumor mass on the right cheek just above the angle of the jaw (fig. 2). All other physical findings were negative. Darkfield examination of fluid expressed with difficulty from this mass was loaded with T. pallidum. The serologic test for syphilis was positive.

The only significant history available was the fact that several weeks before the appearance of the lesion he had used a shaving brush which belonged to a man who was rooming in his house. The owner of the shaving brush was found to have an eruption on the face and palms which was involuting. Only small, slightly depigmented, round macules were seen. In addition, there was an oval depressed scar on the ventral surface of the penile shaft just behind the coronal sulcus. He gave a history of a preëxisting ulcer in that location. The causal relationship here is considerably more than probable.

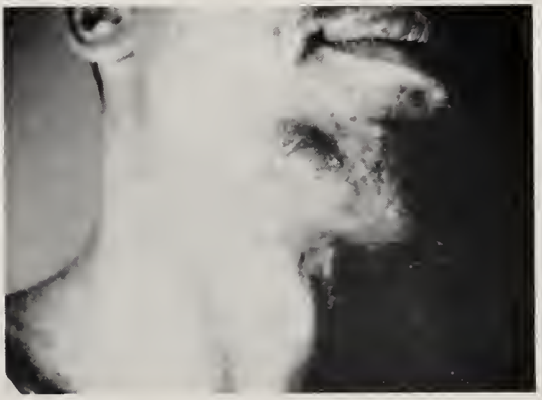

Fig. 2. Case 4. Photograph taken 3 weeks after initial appearance of chancre.

Comment

Four cases of syphilis have been described, 3 of which had demonstrable extragenital chancres. As for the host of the infection transmitted to cases 1 and 3, two possible explanations present themselves. He either had a chancre of the vocal cords or mucous patches in that location. I favor the idea of a chancre because of the complete absence of other forms of secondary eruption and the absence of demonstrable scars of chancres in other locations. Attempts were made to have a visualization of his vocal cords to determine the presence of scarring, but because he was so uncoöperative the examination could not be done. Attempts were also made to obtain photographs of the

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GROUP PSYCHOTHERAPY

Remarks on Its Basis and Application*

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PEOPLE are increasingly curious about group psychotherapy. This curiosity is usually strongly blended with the hope that perhaps this may be a way of treatment which when developed will enable us to afford some medical relief to the increasing number of neurotically and psychotically disabled in our community.

This paper is intended to serve as an introduction to the subject of group dynamics and to the various approaches to those dynamics. Description of the work of individual contributors will be subordinated to the mechanisms of group therapy. I am cognizant of the inadequacies of second-hand descriptions of another person's work.

Man, in common with many other animals, has to coöperate with others of his own species for survival. He "naturally" does things in groups, activities ranging from actively coping with a hostile animate environment to obtaining personal relief from fears of forces greater than himself. When man has become disturbed he almost invariably gathers in groups of his fellows, to seek solace, obtain information, or take action.

"Birds of a feather" always flock together, whether they be active and curious youngsters in play and study groups, rebellious adolescents in antisocial groups, other adolescents in swoon or athletic groups, economically depressed or socially disturbed adults in reform groups, or lost souls in cult groups. There are many more types of groups, including the various ones "normal" to our culture, such as the various lodges and business men's clubs, each of which meets some needs of its members.

Let us look briefly at what happens in "normal" groups for the light it may throw on the therapeutic group. Sociologists have noted that groups of people living together tend to have certain characteristics. They tend to form a group way of doing things—mores. Members tend to compete for group approval, with patterns of dominance. Leaders arise out of this interaction, and the need of the group for working together, or integration, is most readily obtained.

The members of the group are concerned with security in relation to other group members and to their environment. Involved in this is a concern for status, or a concrete manifestation of the approval of the group.

The relationships of the members of the group are constantly changing, a dynamic state of affairs. Members are continually sensitive to their standing with other members, and to their biologic needs. How much on edge they are in these regards depends on the state of the physical environment and their previous relations with other group members (the psychogenetic factors).

Basically related to the group's dynamics or way of getting along is the question of purpose. The direct and indirect meaning of the group in relation to the biologic needs of the individual's growth and propagation, and its apparent progress in this direction, has been increasingly noted to be of importance to the healthy functioning of the group.

Neurotic and psychotic members of "normal" groups have, for reasons beyond the scope of this paper, relationships marked by insecurity as relates to their fellow man. Their interpersonal barriers of distrust, feelings of discrepancy (inadequacy and discrimination), and distortions in thought and behavior patterns are part and parcel of this insecurity. The emotional isolation which is both cause and effect of the disturbed relationship is maintained through various mechanisms.

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At first glance it would seem that congregation of these individuals in groups of their kind would result in a worsening of their disturbed state. One would think they would tend to "pick" on each other even more than otherwise through the familiar mechanisms, and that they would tend to raise their barriers even higher than with "normal" people.

One might expect that a group, in not meeting the greater psychologic needs of the neurotic and psychotic, would diminish their security and distort still further their relationships. One might expect that their approval-getting mechanisms would be distorted to the extent that group-living would be impossible.

This expectation, although justified in ordinary groups of neurotics and psychotics, has been shown not to be applicable in groups that have a therapeutic atmosphere. This therapeutic atmosphere, the new element in the lives of the neurotically and psychotically disturbed individual, is brought to the group by the approach of the group leader, the therapist.

Wittingly or unwittingly, each group therapist assumes leadership of the group. He does this in a variety of ways, among which are addressing the group as a whole and regarding the group as possessing a common denominator which the members in some part recognize, that is, a neurotic or psychotic way of life.

Through word and example he gradually leads to an atmosphere of acceptance of the group members of each other as chiefly human beings in distress who need and want help. This way of looking at and doing things gradually becomes the mores of the group.

The striving for acceptance of the group members still goes on, but upon a different backdrop. Their hates, jealousies, and attitudinal distortions are still present, as they are in their ordinary groups, but the members are there to help them "get over it." Their disturbed way of relating themselves to people, transference neurosis, parataxic distortion, "screwball attitudes," etc., are worked out by the patients face to face with their human environment, living with them in a therapeutic role.

The leader gives the group purpose; getting well is possible and desirable and increases the member's standing in the group. Through learning to relate himself to other group members, the neurotic and psychotic achieves the ability to do so outside the group, in the other social groups he is a part of.

This theme, with variations, is present in practically all the group therapy attempted to date. In some, the role of the therapist is the dominant one, with "treatment" of the entire group by relaxation exercises, analytically oriented lectures, or inspirational talks. In others, the therapist concentrates his attention on one member, giving him analytic-type treatment, while the others, participating but little verbally, profit by the experience of the helped one. In still others, the therapist, after aiding the group to attain a mores of accepting and helping one another, allows the members to work out their relationships with or without going into past experiences.

On the basis of the relationships formed in the group, I would refer to the therapeutic approaches just noted as first, therapy of the group as a whole, with relatively little interaction between members, and emphasis on the activity of the therapist. The relationship of the therapist and its members is on an inspirational and repressional basis, as manifested by verbal intercourse principally through inspirational sentiments and repression of problems and difficulties.[1, 2, 3, 4]

Pratt,[1] to save time, gave a class in personal hygiene to a group of tuberculous patients. He noted the mental stimulation, encouragement, and enjoyment of their own society, and continued its use. He evolved a class technic, following the lead of the psychotherapy of his day of treating other chronically ill patients, later applying it to psychoneurotics at the Boston Dispensary.

After a careful workup the patient was referred to the class, which came to be known as the "Thought Control Class." After the patients, both old and new group members, were seated in an informal and cheerful atmosphere, they were directed to close their eyes, picture to themselves a lake in the wilderness on a quiet summer afternoon with its surface smooth as glass, and relax one group of muscles after another until the entire body was limp. After 30 seconds all those who felt relaxed were asked to raise their hands. A short inspirational talk by the doctor would follow, mainly addressed to the new members. Then members would be asked to tell the group what they got out of the class, and how it had helped them. Unsolved problems and unhelped symptoms were taboo at this point, being relegated to individual interviews.

These neurotic patients, receiving the support of the group, could face the nonorganic nature of their illness, unburden themselves, attain some self-importance and recognition, and see the similarity of their difficulties. The emphasis was on improvement, and on the cheering effect of seeing others in the same "boat" making the grade.

Procedures similar to this were followed by other doctors in the same clinic (Harris,[2] Rhoades, etc.) and by Samuel B. Hadden[5] in Philadelphia. There was apparently a gradual increase in psychodynamic formulation and explanation by the doctor, and a tendency toward interaction between members of the group to help one another express and understand himself.

Thomas,[6] in an excellent review of the literature up to 1943, has called the method of Pratt, Harris, Rhoades, Marsh and also Blair of Great Britain (and Hadden's early work) the repressional inspirational approach. This referred to the repression of the inner conflicts, and the inspiration toward improvement received from the therapist and other members of the group.

A form of group therapy, Alcoholics Anonymous, administered outside of direct medical supervision, has spontaneously arisen in this country, embodying the repressional inspirational approach. The Alcoholics Anonymous movement is steadily spreading and is credited with salvaging many otherwise hopeless alcoholics. Tiebout[7] has contributed an excellent article on this subject, delineating the intense relationship developed between the members of the Alcoholics groups.

The next modality would be informational talks, analytically oriented, with verbal intercourse principally on an interpretative and informational level.[3, 8]

Lazell,[8] in experiments at St. Elizabeths Hospital in the early twenties, gave groups of about 20 patients psychodynamically oriented lectures in language simple enough for the patients' understanding at stated intervals. He reported: "Silent, dreamy boys suddenly became interested and drank in every word, realizing that here was someone who understood their troubles. Ashamed of themselves and suffering from a profound feeling of inferiority, guilt, and failure, and afraid to confess to anybody because they considered themselves unique in their mental degradation, they were greatly relieved when told that all mankind has to contend with the same emotions that had broken them down."

Verbal intercourse between patients, as reported, was even less than in Pratt's method.

A third method is that of therapy of the individual by modified analytic technics, in which the therapist plays a dominant role.[9, 10, 11] Schilder's group[9] was prepared for the sessions by individual therapy; and after writing out their biographies, they assembled in a group. The biographies were read by the patients and interpreted by the therapist. After the group was sufficiently advanced, members of the group would offer interpretations. Members of the group would be asked for their associations. The therapist would clarify the mechanism displayed. Patients developed relationships with other group members. They attended classes as long as they needed to develop good social adaptation and good insight into the mechanisms and origin of the disturbance.

Group interactive therapy, the next approach to be considered, is therapy achieved chiefly through the working out of relationships of group members with each other. The therapist relates himself to the group in an acceptant, helpful role, but once this becomes the group mores, he withdraws from active verbal intercourse.[12, 13, 14]

A ward group at St. Elizabeths Hospital, containing the most disturbed and destructive patients—paranoid, hebephrenic, catatonic and schizophrenic prison reactives—is treated by daily group psychotherapeutic sessions. The group, starting with the more accessible patients, gradually encompassed the entire ward population. Interacting about ward problems, it evolved a "we" consciousness, group mores, and rudimentary group institutions. The therapist, through empathy with the individual, was able to lead the patients to relate to each other in a therapeutic manner, i.e., to motivate and help each other to attain the insight and change needed to get along better in the group and then in the outside world. The group as a whole could endure reality much better than when in individual treatment, the immediate reward being group acceptance and approval. The members at first displayed marked affect (hostility, depression, manic reactions), and then became increasingly coöperative as they helped each other toward common goals. Delusional and hallucinatory content was looked at for their basic meaning relative to the patient's needs, security and satisfaction, rather than reacted to as such.

Slavson[15] utilized the group interactive approach in a play activity technic for children and adolescents, without discussion by group members of their relationships. To the children in Slavson's groups at the Jewish Board of Guardians in New York City, the group is a play project. He finds play materials and a therapist who does not interfere with any of the children, offering what Slavson calls "unconditional love." The child, working through his former relationships, makes his adjustments to all sorts of interpersonal situations. After the play session the group eats together, a procedure found by Slavson to be of great value in socializing the individual. Antisocial children who belonged to the diagnostic category of "psychopath" were excluded from the group.

Moreno's psychodrama method of group therapy,[16] introduced first into a public mental hospital at St. Elizabeths in 1943, is in a class all by itself. The therapist acts as a dramatic director who, with the aid of the patient, sets up scenes involving important conflict situations in the patient's life. The patient, in company with other people called auxiliary egos, who take the roles of significant figures in his life, acts out past and present life situations.

This acting out of relationships is made as lifelike as possible through the dramatic arts and special training for the auxiliary egos. It is complicated for therapeutic purposes by the dual relationships going on. The patient, or real person, is acting as if he were in a former situation, and the auxiliary egos are acting as if they were persons other than themselves. The patient cannot help responding to the auxiliary ego as a personality in his own right.

The theoretical or practical implications of this state of affairs are manifestly quite difficult to assay. However, a therapeutic atmosphere is apparently present in this group, and the mechanisms apparently are similar to those in the interactive group therapy noted above.

What happens to the individual in these forms of therapy? Apparently, from the reports in the literature, in all methods the patient receives a sense of value as a member of the group. His self esteem is raised by the act of being able to help another person. His sense of aloneness tends to be dispelled by the experience of seeing many like himself, with the same problems.

He undergoes desensitization to his difficulties through hearing about similar ones and through recital of his own. He feels more at home among people of his kind and is able to express himself more easily in this "natural" situation.

Not only are these people like himself, but as a result of the therapeutic atmosphere he finds himself in contact with a whole group of people who are easier to get along with and who have his interests at heart. In addition, the group has a purpose and is "going places."

As in individual psychotherapy, the person in group therapy relates himself to other group members and the therapist as he does to the other significant figures in his life, and through their acceptant, non-critical, non-hostile manner he is able to bring up repressed material and also to work through his distorted relationships.

The degree of depth this sort of experience can reach is determined chiefly by the therapist and certain natural limitations of the method. When the therapist keeps the group members from relating themselves to each other except through an inspirational way, they can receive only the benefits of the mutual support that group living with a purpose gives one. However, when the patient is able to work out his relationships with people in the therapeutic atmosphere of the group, the depth is determined by the practical considerations of the time he has to bring out his feelings, and the skill and understanding of the others, including the therapist, of his problems. The latter is the more important of the two.

Research on the dynamics of group therapy and its relationship to individual therapy is one of the "musts" of psychiatry at this time. Those who have delved into this mode of therapy have usually come out optimistic and often enthusiastic. Their experiences tell of certain unique advantages of group therapy. What precisely are they? What is the scope of this discipline? What relationship, synergistic it is hoped, does it have with individual therapy? These and many more are questions which have to be gone into deeply before this therapy becomes more than the promise it is today.

BIBLIOGRAPHY

1. Pratt, J. H.: Hosp. Social Service, 1922, **6**, 401.
2. Harris, H. L.: New England J. Med., 1930, **221**, 1.
3. Marsh, L. C.: Ment. Hyg., 1933, **17**, 396.
4. Blair, D.: Lancet, 1943, **1**, 204.
5. Hadden, S. B.: Am. J. Psychiat., 1944, **101**, 68.
6. Thomas, G. W.: Psychosom. Med., 1943, **5**, 166.
7. Tiebout, H. M.: Am. J. Psychiat., 1944, **100**, 468.
8. Lazell, E. W.: Psychoanalyt. Rev., 1921, **8**, 168.
9. Schilder, P.: Ment. Hyg., 1939, **23**, 87.
10. Wender, L.: J. Nerv. & Ment. Dis., 1936, **84**, 54.
11. Blackman, N.: Occup. Therapy, 1940, **19**, 293.
12. Ackerman, N. W.: Psychiatry, 1944, **7**, 341.
13. Heath, R. G.: Quart. J. Stud. on Alcohol, 1945, **5**, 555.
14. Abrahams, J., and McCorkle, L. W.: Am. J. Sociol., 1946, **51**, 455.
15. Slavson, S. R.: An Introduction to Group Therapy. New York: Commonwealth Fund, 1943.
16. Moreno, J. C.: Who Shall Survive? New York: Nerv. & Ment. Dis. Monographs, 1934.

President's Page

ACTIVITIES AT SOCIETY'S HEADQUARTERS

In its efforts to serve the membership better, our Medical Society is literally bursting its seams. Present office space has long been inadequate, and the continually expanding program has made additional space essential. Plans are now under way to remodel the ground floor of the property at 1710 M Street, and to construct a passageway to the Medical Society building at 1718 M Street. When completed, the Society's staff will be better able to render more efficient service to the membership.

Few of our members realize the variety and the amount of work being carried on in our Executive Offices. These range from arranging meetings of committees to preparing the MEDICAL ANNALS for publication. Among the major undertakings is the ANNUAL SCIENTIFIC ASSEMBLY. It requires at least eight months of hard work on the part of all the staff before the opening day. More than 2,000 letters were written in connection with the last ASSEMBLY, which gives one an idea of the enormous amount of work entailed. The monthly accumulation of material for the MEDICAL ANNALS, including the editing and proof-reading of the material; the operation of MEDICAL BUREAU, which will handle a quarter of a million calls by the end of this year; and the regular scientific programs are all time-consuming tasks.

This is only a partial list of activities at the Society's headquarters. Many other duties fall on the shoulders of the staff. Among these are the personal advice and assistance given to physicians, dissemination of information to the public, which, by the way, is rapidly becoming one of the most important functions of our Society, and the handling of many details, including the collection of dues of physician-subscribers to Group Hospitalization, Inc.

In its new offices, the staff at the Society's headquarters will be better able to perform their numerous tasks and to serve those of our membership who avail themselves of its services. The staff, of course, is most anxious to render service to those of the membership who do not now take advantage of the benefits available to them. There are still too few of our members who make use of the Society's facilities.

Incidentally, if you have not availed yourself of the services here mentioned, and others which you can learn about by making inquiry, you are invited to do so. The staff at headquarters is anxious to be of every assistance possible.

Raymond T. Holden

Editorials

ADAPTATION OF THE NEWBORN FOR NORMAL BEHAVIOR

Human development is dependent on three fundamental processes: anatomic, physiologic and behavioral. Each process is independent and lends itself to evaluation, but is intimately dependent upon the others. The mature adult demonstrates the care and attention given to each of the three. Defects in either pattern are manifest in poor physical development, imperfect body functions, or maladjustment to one's environment.

Mortality and morbidity rates were high in the early days of the 20th century. Interest in infectious diseases was acute, especially in regard to the treatment of diphtheria with antitoxin and inoculation against typhoid fever. The great scourge of dysentery in the young was traced to contaminated foods, principally milk; pasteurization was accomplished.

World War I stimulated considerable interest in nutritional and physical defects which were correctible and preventable. The White House Conference on Child Health demonstrated the need for close supervision of the growing child. Emphasis was almost entirely on his anatomic and physiologic well being. It was decreed that he gain a predetermined number of pounds and inches by consuming standardized formulas and measured food calories, imbibe units of vitamins, and sleep certain hours at stipulated intervals. No physical weaknesses nor defects must be tolerated! No one, however, evolved a formula for securing submissive coöperation of the negative two-year-old!

Under this régime the behavioral pattern was lost sight of—it was predestined to suffer. Competition, pressure and tensions increased at an alarming rate. This state of affairs attracted the attention of the psychiatrists, during World War II, in the number of psychoses and neuroses discovered in the armed forces. These investigators found that the majority of maladjustments had their origin in infancy and childhood. In short, the present generation of middle-aged parents had failed in the composite upbringing of their children. This failure is reflected in the present trend of more active participation in prevention of psychotic and neurotic illnesses.

Our profession has a grave obligation to educate prospective parents in their new venture, to help adapt them to the attitudes necessary to the proper care of the newborn, to demonstrate the necessity for curtailing their former freedom from responsibilities, to help them to understand the developing infant and child in all his potentialities. We and they must be made aware that the behavior pattern begins to form with the first impact of the newborn to his environment.

During the newborn period the most critical and sharply defined adaptations are necessary. The simple fact that weight loss is a normal physiologic process must be accepted by the parent without concern. The need for the infant to nurse from the mother must be given adequate evaluation. Hunger satisfaction of the newborn on a selective schedule anticipates frustrations. These simple adaptations of infant and mother require an increased period of companionship above that usually allowed in the hospital. This homelike atmosphere, with sympathetic professional assistance, gives the mother confidence and understanding so sorely needed.

When this friendly environment makes its first impact on the infant, he is conditioned to influences of unselfishness and tolerance. He responds to the comradeship of his parents, who give of their time and energy. He responds to loyalty and courage and honesty and authority as his mentality develops. Pressure by the parents is unnecessary in teaching self feeding, good toilet habits, proper attitudes to playmates, and later to school. Assumption of duties and responsibilities and development of kindliness and reasonableness develop an adjustable behavior pattern.

P. A. McLendon, M.D.

WASHINGTON CHEST X-RAY SURVEY

In January 1948 the Washington Chest X-Ray Survey will get under way. This survey is a joint endeavor of the District of Columbia Health Department, the U. S. Public Health Service Tuberculosis Control Division, and the District Tuberculosis Association, with the Health Department as the directing agency.

It is the purpose of this city-wide Survey to X-ray all adults in the District of Columbia over the age of fifteen in as short a time as possible. By means of follow-up procedure nearly all cases of tuberculosis discovered in the area could be under Public Health supervision soon after the conclusion of the Survey. In addition to the advantages realized from bringing a sizable number of patients under medical care and insulation, the Survey will reveal for the first time in the District of Columbia the problem of tuberculosis in its entirety. The information will permit the District of Columbia to plan for an over-all community-wide program.

To facilitate the carrying out of this project, the agencies involved appointed Dr. F. J. Weber, Chief of Control Division of the U. S. Public Health Service, Mr. E. K. Funkhouser of the District Tuberculosis Association, and Dr. A. B. Coulter, Director of the Bureau for Tuberculosis of the District Health Department, to act as an Operating Committee. Dr. Ruhland, the Health Officer, designated Mr. William E. Leahy, well known attorney and former Director of the Selective Service, as General Chairman of the Survey.

The goal for this Survey is twofold: first, to discover all undisclosed cases of tuberculosis and the placing of them under medical supervision; and second, a long-range study as to the proper disposition of asymptomatic minimal tuberculosis. This study will be under the direction of Dr. A. C. Christie, the Chairman of the Medical Technical Committee. The plans of this Committee are still in the formative stage and will be presented to the Medical Society of the District of Columbia at a later date.

It is to be hoped that the medical profession and the Health Department jointly will pursue a plan which will have for its objective the proper management and the ultimate outcome of the minimal asymptomatic tuberculosis individual.

If one can assume that 6,000 cases will be found in the Survey, providing all adults are X-rayed, approximately 4,200 will fall in this classification. Many of these cases will be, or have been, under the care of private physicians. In routine medical practice, the majority of these cases are found to be apparently inactive and discharged, and the patient is lost sight of. It is planned that by a closer working relationship between the private physician and the Bureau for Tuberculosis all cases found in this Survey will be periodically studied for at least two years in order to determine whether or not we have been too optimistic as regards "this ultimate outcome" and also too casual in making a diagnosis of "arrested" in minimal tuberculosis cases.

A. Barklie Coulter, M.D.
Director, Bureau for Tuberculosis,
District of Columbia Health
Department

THE OBJECTIVES OF ANESTHESIOLOGY

The celebration of the ether centennial last fall was a time of taking stock in anesthesiology. The view taken, however, was largely backward. This historical approach is good only as it aids future progress. After only one year in the new century of anesthesia it is apparent that growth and change in this specialty are so rapid that continual reëmphasis and even revision must be made in objectives.

The objectives are both immediate and remote. Ultimately it is desirable that anesthesiology be generally accepted as a major specialty in its own right. Although this has been accomplished in favored institutions and their surrounding communities, the steps toward broadening this happy state are the present concern.

First of all it is necessary that weaknesses within the specialty itself be recognized and changed.

There are three general groups giving anesthesia—physicians, dentists and nurses. There is little coöperation among them, often not even a willingness to recognize and face mutual problems. Personnel in the field is so limited that no group could possibly be displaced without limiting sharply what is now an inadequate service to the whole public. It seems only common sense that the large organizations should study how to make the most of all the help now available as they plan for an ideal future setup.

All of those who now give anesthesia must in their own thinking, and especially in their public relations, stop stressing gadgets, technics, and drugs. Good management by competent personnel is the first essential to real specialty status. The tools of the trade are only the means to an end and will be understood only by those who use them. They should never be given important consideration in public. The physician-anesthesiologists must all individually clarify their teaching objectives and devote considered time and effort to pursuing them before the entire profession and the public.

Outside the immediate field of anesthesia there are three groups whom it is desirable to influence. Since anesthesiology is essentially a hospital service, it follows that these institutions must be shown the advantage to themselves of properly organized and well run departments. The hospitals must allow adequate compensation to their anesthesiologists and not appropriate their funds for deficits elsewhere. They must give professional status to specialists in this field equally with other specialists on the staff.

Every medical school should have a full department of anesthesiology. All undergraduates should know enough about this specialty to appreciate and support its aims and to use its service later in the practice of medicine. And, of course, the medical school hospital should aim at the ideal in its own anesthesia service.

The lay public is the third group to be influenced by good public relations in anesthesiology. They should realize that good anesthesia is good insurance; that competent management is worth what it costs; that the performance of this service is not casual and dependent upon a bag of tricks, but that it is an essential member of the team with good surgery; and that, if the patient dies, it is more likely from poor anesthesia than from poor surgery.

If anesthesiology cleans its own house and then works for the ideal organization in hospital and medical school, it must follow that this service, on a higher plane than any we now know, will be an integral part of good medical care.

D. S.

In and Out of Focus

BY THE OBSERVER

The Assembly Takes on Stature

Anyway one looks at it, the 18th Annual Scientific Assembly topped all its predecessors. Not only was the scientific program one of the best offered, but the exhibits were of unusual excellence. In view of the high standards attained, it was perhaps not too surprising that the attendance broke all previous records. Naturally this was very gratifying to the Committee on Arrangements. There is little satisfaction in putting on a fine meeting unless it attracts those for whom it is planned.

The following is an analysis of attendance figures:

Members	929
Visiting Physicians	532
Residents	163
Interns	93
Medical Students	325
Nurses	285
Dentists	14
Pharmacists	26
Technicians	52
Miscellaneous	609
Total	3,028

One might elaborate considerably on various phases of the program. Due to restrictions of space, however, comment on each feature must of necessity be brief.

As stated previously, the scientific program this year was superior in every respect. Several physicians spoke to your Observer about the program, comparing its quality favorably with national meetings they had recently attended. They named organizations which are known to every physician for their superior program material. It is perhaps best not to identify them, as much as it would please those responsible for the Assembly to do so.

The night before the Assembly it looked as though the Scientific and Public Health Exhibits would be only partially completed before the meeting opened. This so disturbed Dr. Robert H. Groh, General Chairman, and some of his associates, that when it became evident the contractor could not finish the task, they took over with the assistance of a part of the contractor's crew and some outside help. The job was finished at 4:30 a.m. on the opening day of the Assembly. Except for a handful of exhibitors, none of the hundreds who streamed to the meeting knew about the all-night shift which made the exhibits possible.

The Public Health Exhibit was a new feature and in some ways an experiment. Thousands of Washingtonians and suburbanites viewed it. Their comments were uniformly favorable and it seems certain that it will become a permanent feature of the Assembly. Sponsors of the Exhibit were the District Health Department, the District of Columbia Division of the American Cancer Society, the District of Columbia Chapter of the American Red Cross, the District of Columbia Tuberculosis Association, and the Medical Society of the District of Columbia.

One of the regular features of the Assembly which the Committee on Arrangements always approaches with trepidation is the Public Meeting. There are so many public functions in Washington that most meetings are poorly attended. Only the most timely subjects and topflight speakers will arouse interest.

In the past, eminent public figures, many whose names are household words, have been chosen because of their drawing power. However, in recent years emphasis has been placed on health subjects. Speakers have been selected for their ability rather than for their public reputation. Attendance has not suffered a great deal, although it must be admitted that more effort has been required to make the Public Meeting a success.

The subject selected this year, "Our Youth Today—A Challenge to American Parents," was a particularly happy choice. Presiding most graciously at the meeting was the Honorable G. Howland Shaw, former Assistant Secretary of State. An unusually capable array of speakers included the Honorable Theron L. Caudle, Assistant United States Attorney General; Dr. Miriam Van Waters, Framingham, Mass.; and Dr. George E. Gardner, of Boston, Mass. Some 800 to 1,000 persons were in attendance. At the conclusion of the formal talks, speakers were questioned at length.

Luncheons were, as usual, well attended. Attendance is never any problem at the luncheon on the first day because it is free to Active members of the Medical Society. Contrary to the belief of many members who have spoken to the Society's officers, this luncheon is not paid for out of their dues. It always has been and still is made possible because of the income from technical or commercial exhibitors.

Dr. Louis M. A. Krause, Associate Professor of Medicine of the University of Maryland, was the speaker at the Society's luncheon. He was, as usual, most articulate and effective. Dr. Krause has become a great favorite among Washington physicians, who always turn out in large numbers to hear him.

On Tuesday, October 7, the second day of the ASSEMBLY, the Georgetown University Medical Alumni Association presented Monsignor Fulton J. Sheen, Professor of Philosophy at Catholic University. Few speakers, in your Observer's experience, have held an audience like Monsignor Sheen held his. When he began speaking, a hush fell over the assemblage. There was not a sound to be heard other than the speaker's voice. Here was a master of the spoken word who stirred his listeners as very few speakers of our day are capable of doing.

On the last day of the ASSEMBLY, Wednesday, October 8, Dr. George F. Lull, Secretary and General Manager of the American Medical Association, was the speaker at a luncheon given by the George Washington University Medical Society. Dr. Lull devoted himself to the activities at AMA headquarters. As usual, he was forceful and clear and impressed the gathering most favorably.

The ASSEMBLY came to a close on Wednesday night with the Annual Dinner, designated Past Presidents' Night. Reference is made elsewhere in this column to the past presidents who were honored guests. The principal speaker at the dinner was the President of the American Medical Association, Dr. Edward L. Bortz, who spoke on "Medical Statemanship." His address was widely commented on in the press the following day.

All in all, this ASSEMBLY was a most gratifying success to those who had devoted months to preparing for it. Much of the credit must go to Dr. Robert H. Groh, General Chairman, who was tireless in his efforts to make the ASSEMBLY a success. Generous support was given him by the Vice Chairman and the various chairmen of committees, to whom were delegated specific tasks. Mention should also be made of J. Richard Connelly, Assistant Secretary of the Society, who was indefatigable in attending to details of what has become one of the largest state medical meetings in the country.

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"The Vital Flaw"

Fed up with what is described as "questionable practices and unethical policies," 880 doctors of the professional staff of San Francisco's Health Service System have submitted their resignations. They will become effective immediately upon being transmitted by the San Francisco County Medical Society to the Health Service Board, which administers the affairs of HSS.

HSS is a compulsory sickness insurance plan for the city's employees. It has long been under fire, and a crisis in its affairs has been imminent for some time.

> "We have repeatedly warned," the Society's Board of Directors states in its letter to HSS, "that reputable doctors could not continue to serve the System unless conditions were corrected.
>
> "The advice of the medical profession has been entirely disregarded and our communications have gone unanswered. Every suggestion we have made, in an attempt to avert the impending crisis, has been brushed aside. Under the circumstances, if there is a breakdown in the Health Service System, your Board must accept full responsibility for its collapse."

What apparently aroused the ire of the Society's Board of Directors was a letter directed by the System's Medical Director, Dr. Alexander S. Keenan, to all physicians on the HSS panel "pleading that the Health Service System was in financial difficulties and calling on the doctors to lower the quality of medical care provided city employees and insured members of their families."

> "This indefensible directive from the HSS management," the Board continues, "has never been recalled or modified in any degree, despite the fact that our Society warned your Board that we could not countenance treating city employees as 'second class patients,' or endangering their health by refusing them adequate medical attention.
>
> "This HSS directive, in direct violation of sound medical practice, asked doctors on your professional staff to:
>
> 1. Limit and restrict the use of laboratory tests, X-ray examinations and normal diagnostic procedures—and to substitute 'routine examinations' for careful, scientific diagnosis. The diagnostic procedures thus restricted are essential safeguards for the early detection of cancer, tuberculosis, pneumonia and other serious diseases.
> 2. Discourage patients with 'minor ailments' from seeking medical treatment and advise them to use 'home remedies.'
> 3. Deny hospitalization to HSS members, except in emergency cases, without specific authorization of the medical director of HSS.
>
> "No doctor could follow that directive from your HSS management without violating his code of ethics—and without endangering the lives of his patients."

The fact that the HSS is a compulsory insurance system is, according to the Board, "the vital flaw." It makes a point of the fact that "city employees are forced to join as a condition of their employment. . . . Like most compulsory systems, it started out by promising too much for too little—in an attempt to stifle opposition to its compulsory payroll deduction features. And like most socialized medicine systems, when financial difficulties developed it first siphoned off funds needed for medical services to help defray the costs of bureaucratic overhead. When that failed to balance the books, the System increased its rates to insured members—and then took the final step, characteristic of all experiments in socialized medicine, by demanding that doctors lower the quality of medical and hospital care provided their patients.

> "Many of our doctors, familiar with the experience of socialized medicine schemes in other countries, were frankly fearful of the consequences when the System was proposed here. But once it was voted and established, they decided to coöperate in an attempt to make it successful and in the hope that it would be kept free of bureaucratic evils and shoddy procedures.
>
> "The experiment has failed.
>
> "It has failed despite the fact that members of the medical profession in San Francisco have contributed hundreds of thousands of dollars in unpaid medical services in an attempt to bolster the System during its continuing financial difficulties."

The Society's Board of Directors recommends to the Health Service Board that it provide the types of medical service furnished Los Angeles city employees. According to the Board, each employee has the following choice: "(1) to make provision for his medical care with his own doctor; (2) to join a voluntary health insurance system with indemnity cash payments to help defray his medical and hospital bills; (3) to enroll as a member of the Voluntary Medical and Hospital Service Plan which will provide him with health care in time of illness."

It is only fair, the Board argues, that employees be given the opportunity to "choose between several systems and select the one that suits their needs."

Our Past Presidents Comments following the Annual Dinner held in connection with the 18th Annual Scientific Assembly, at which the Past Presidents of the Society were honored guests, were most interesting. One of those present expressed surprise at the large number of living past presidents. It was evident, he said, that these men held office when they were comparatively young. Even those who served many years ago still looked surprisingly vigorous. Another observed that they were a most distinguished appearing group.

Elsewhere in this issue of the Medical Annals are pictures of the Past Presidents and their wives. These will have considerable historical interest, especially to future presidents.

Your Observer, who was present at the dinner, reflected on the presidents with whom he had served. Because of close association, he had gotten to know many of them intimately. Without exception he had found them conscientious and diligent officials. Most of them had served the Society in various capacities over a period of several years. A surprising number are still active in Society affairs. Among them are presidents who held office in the twenties and thirties and even in the early years of the century. Not a few have been elected to high office in national medical bodies. Others have been medical educators, contributors of note to scientific literature, and outstanding leaders in the community.

Past Presidents and their wives were introduced to the dinner guests by Dr. Raymond T. Holden, Jr., President of the Society. Dr. William Gerry Morgan, Past President of the Society, and the only Washington physician elected President of the American Medical Association in the past fifty years, addressed the assemblage briefly.

Dr. Morgan said:

"I was brought up under the rule that a child may be seen but not heard. When I arrived at the veal-and-calf period in the practice of medicine, I paraphrased, as it were, that saying to run: An old doctor should rarely be seen and never heard in medical meetings. As the years have rolled by, I am more and more convinced it is a Golden Rule to be followed; hence my remarks will be brief.

"From the time of its organization in September, 1817, The Medical Society of the District of Columbia has been a vigorous, though small Society, devoted to the well-being of the community and of the physicians in general. When I began to consider what I might say in the few minutes which I had allotted for it, I thought I might mention a few of the highlights in that enviable record. However, a few moments spent in looking through the published history showed me the futility of such an attempt. Nevertheless, I cannot resist calling attention to three steps taken because they have had such far-reaching beneficial results:

"When Dr. Davidson gave expression to a belief which had been crystallizing in his mind for many months, that the time was long overdue for the Society to own and occupy its own home, and when through his efforts the concept was brought to splendid fruition, a marked forward step had been taken.

"During his presidency, Dr. Charles White conceived the idea of holding an Annual Scientific Assembly, and the first one was held that same year. Each succeeding one has been more successful than the preceding one. Dr. White, you must be very gratified that you fathered such a splendid official child.

"The third highlight which I shall mention was the decision to employ a full-time Executive Secretary. The Society is indebted to Dr. Verbrycke for carrying this plan to a successful conclusion, and more especially for enticing Ted Wiprud to undertake this work. Mr. Wiprud has been highly efficient and has piloted the Society through some stormy and troublous waters. We Past Presidents give thanks in the name of the entire membership for all that you are doing to make our Society work smoothly and efficiently.

"Our Society has consistently chosen as its presidents men of ability and vision. A few of these presidents have had opportunities through the exigencies of the times to render outstanding service to the Society and community. It is my considered opinion that all of the Past Presidents could and would have given equally meritorious service under like circumstances.

"Few state medical societies could assemble as many past presidents as we have here tonight. This is not due to the longevity of doctors but to the fact that the Society has elected young active men of ability as its presidents.

"President Bortz has conferred a signal honor upon our Society by coming to us for this occasion. Dr. Bortz has made an enviable record as a clinician, as a military man, and as a private citizen.

Past Presidents' Night at the Statler

Top row (left to right): Dr. A. B. Bennett, Mrs. A. C. Christie, Dr. Christie, Mrs. W. H. Hough, Dr. Hough, Dr. H. H. Kerr.

Dr. H. C. Macatee, Dr. J. S. Wall, Dr. C. S. White, Mrs. White, Dr. W. G. Morgan, Dr. J. B. Nichols, Mrs. O. B. Hunter, Dr. Hunter.

Dr. T. E. Neill, Dr. Sterling Ruffin, Mrs. Prentiss Willson, Dr. Willson, Mrs. H. A. Fowler, Dr. Fowler, Mrs. Neill.

Center row (left to right): Mrs. J. H. Lyons, Dr. W. J. Mallory, Mrs. F. R. Sanderson, Dr. Lyons, Mrs. A. M. MacDonald, Dr. MacDonald.

Dr. Morgan, Dr. E. L. Bortz, President of AMA.

Mrs. W. P. Herbst, Dr. Herbst, Mrs. W. E. Clark, Dr. Clark, Mrs. W. M. Ballinger, Mrs. J. N. Greear, Dr. Greear.

Bottom row (left): Brig. Gen. W. H. Graham, Mrs. Graham; (right) Dr. Herbst, Dr. Nichols.

"Dr. Bortz, you are a worthy successor to all those men who have preceded you in the highest office in the gift of American medicine. I salute you, sir, and on behalf of the Past Presidents, I thank you for being with us tonight and wish you every measure of success in the future.

"We, the Past Presidents, deeply appreciate the honor which has been conferred upon us tonight."

The living Past Presidents and the years in which they served are:

Edward A. Balloch	1909
John B. Nichols	1912
Edward Y. Davidson	1916
William Gerry Morgan	1919
Henry C. Macatee	1921
Joseph S. Wall	1926
Charles S. White	1927
Oscar B. Hunter	1928
Harry H. Kerr	1929
William H. Hough	1930–31
Arthur C. Christie	1931–32
H. A. Fowler	1932–33
Prentiss Willson	1933–34
A. B. Bennett	1934–35
Sterling Ruffin	1935–36
Thomas E. Neill	1937–38
William J. Mallory	1938–39
John Hugh Lyons	1939–40
Daniel LeRay Borden	1940–41
Henry R. Schreiber	1941–42
A. Magruder MacDonald	1942–43
Fred R. Sanderson	1943–44
James N. Greear, Jr.	1944–45
William Earl Clark	1945–46
William P. Herbst	1946–47

One often hears it said that men should be honored for their accomplishments while they can still enjoy the recognition given them. That may be a trite statement, but it is nonetheless a true one. Our physicians should nourish the human touch for their distinguished fellow practitioners. That is not easy to do in a city like Washington where physicians are surfeited with social functions. Nevertheless, physicians should not lose sight of the fact that the real values in life lie in friendship and service to others.

At this point it might not be amiss to suggest that serious thought should be given to the establishment of a Fifty-Year Club such as was described by Dr. Harold M. Camp, Secretary of the Illinois State Medical Society, and editor of its journal, in the July number of the MEDICAL ANNALS. Such an organization would afford members of the Society an opportunity to show physicians who have served the community honorably and well for half a century that their colleagues hold them in high regard and that they have not been forgotten.

Society's Offices to Be Enlarged

The Medical Society is justly proud of its building at 1718 M Street. Few who pass its doors are aware that it houses an auditorium seating nearly 500, a spacious and unusually attractive library, and the offices of the Society.

Those who visit the building for the first time are not only surprised but are impressed; those who see it daily are equally appreciative of its beauty and dignity. After nine years in the service of the Society, your Observer still regards it as the most attractive home of a professional organization he has seen.

Imposing and utilitarian as it is, the building was never designed with offices in mind. For many years after it was built in 1920, no offices were permitted on the first floor. The Secretary's office was on the third floor, in what are now the storage rooms. Later, it was moved to the first floor in a room opposite the Board Room. Here the office staff held forth until the coming of the first full-time Secretary, who now occupies the Board Room, the staff carrying on in the old office.

In recent years, the Society's activities have expanded rapidly, in fact, to such an extent that the Executive Board, to whom the matter was referred, agreed it was imperative that something be done at once to provide additional office space. The Society owns an adjoining building at 1710 M Street, which is now largely used as a rooming house. The first floor front apartment, however, is occupied by MEDICAL BUREAU, the Society's telephone exchange. Renovated and redecorated about two years ago, it has provided the BUREAU with comfortable quarters; however, because of the BUREAU's growth, they are rapidly becoming inadequate. The Board therefore decided that it was not only desirable but essential that the Society take over the entire first floor of the building, remodeling it for the Society's use. The BUREAU will occupy the center of the floor; the remainder will be given over to offices of the MEDICAL ANNALS, the bookkeeping department, and a mimeograph and addressograph room which will be moved from the third floor of the Society's building. The latter space will thereafter be used to store records and books.

The House Committee, having been given authorization to go ahead with the work, has proceeded to obtain bids. None had been accepted when this was written.

The present arrangement in the Society's offices reduces the efficiency of the staff by at least 30 per cent. There is so much noise and confusion that those who work in the office find it difficult to concentrate. Telephone discussions going on simultaneously and the clatter of typewriters in cramped quarters are most disturbing. Naturally, the Society's employees are looking forward to the new arrangement with keen anticipation.

As should be apparent, the Society's membership will benefit as a result of the expansion, not only because of increased efficiency of the staff, but because it will make possible the inauguration of projects which are impossible under present conditions.

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In the Name of Science

No one can accuse cultists and the borderline practitioners in the healing art of being overly modest. In fact, they frequently demonstrate what can be accomplished by enterprise alone. A case in point are the chiropractors, whose theories and methods have never been accepted by the medical profession as having a scientific basis. Lawmakers, too, have recognized this fact and in many states have enacted so-called basic science laws. Under these laws the chiropractors have been required to take examinations in the basic sciences, which, as would be expected, has automatically eliminated all but a handful from practicing in those states. But chiropractors have not taken this lying down. They are reportedly spending large sums of money to attain a standing comparable to practitioners of medicine.

One of Washington's newspapers recently carried a news article entitled "Chiropractors Launch Plan to Win General Medical Recognition." The article states that the country's 20,000 chiropractors, approximately 100 of whom are situated in the District of Columbia, have announced that they are planning a $9,000,000 five-year program "to win general medical recognition of the profession." The writer observes that "the organized medical profession, led by the American Medical Association, has been skeptical of the claims of chiropractic, but its advocates insist that it should be granted equal status with other branches of medicine."

Unfortunately, too many otherwise intelligent laymen are still shockingly gullible in matters pertaining to health. This perhaps accounts for some of the success which has attended the efforts of chiropractors. Recently they succeeded in obtaining recognition from the Veterans Administration for 17 of their schools in 11 states. Veterans are being trained in these schools under the G. I. Bill of Rights. This is indeed a sad state of affairs. One can guess that great political pressure was brought to bear on the Administration; otherwise, the demands of the chiropractors would not have been acceded to.

It should be clear to the medical profession by now to what lengths cultists and borderline practitioners of the healing art will go in the name of science. Here is further evidence that much health educational work needs to be done by the medical profession and the various health agencies.

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More About Public Relations

With few exceptions, little can be accomplished by any group without public good will. Recognizing this fact, the group must decide how to attain this objective. The suggestion will undoubtedly be made that a public relations program should be undertaken. If this is agreed upon, it will soon become apparent that such a program means different things to different people. Some, as your Observer has pointed out on previous occasions, believe that it consists primarily of "good" publicity. Those who hold such a view insist the press can easily be convinced that only complimentary things be said about the medical profession. This is usually followed by a proposal that a publicity agent be employed. The result is inevitably disappointing. Newspapers have little time for the run-of-the-mill publicity agent, and they will not print his material.

On the other hand, there is the group whose leaders are familiar with what constitutes an adequate public relations program. Under their guidance, an expert public relations counsel is employed. His services come high, and groups employing him must be prepared to make large expenditures because the programs he develops are usually ambitious. They may include pretentious radio programs, costly motion pictures, a highly organized speakers' bureau, carefully edited articles on health for the laity, and innumerable news releases.

Your Observer is not convinced that some of the more elaborate programs are justified. They seem to him much overdone and a questionable investment. On the other hand, he does favor judicious expenditure for a sound, moderate public relations program.

Dr. George F. Lull, Secretary and General Manager of the American Medical Association, in speaking to a luncheon audience during the 18th ANNUAL SCIENTIFIC ASSEMBLY, said that the best public relations consists of 80 per cent doing and 20 per cent publicity. Your Observer has been saying this very thing for a long time. After all, the only purpose of a public relations program is to create good will and understanding. To attain this goal, the medical profession must earn it.

There is no substitute for good medical care provided by competent and considerate physicians. This, of itself, will do more than anything else to instill confidence and create good will. Radio programs, speakers' bureaus and daily health articles are certainly worthwhile as health educational projects, and reflect credit on the profession. Equally important is the development of plans which will relieve the patient who is heavily burdened by costs of illness. There are, of course, many other ways of winning public support, but these are a few of the tangible evidences of the sincere interest in public welfare which deserve and receive public commendation.

It should require no public relations counsel to enlighten physicians on how to obtain public good will. All that is required is common sense. The services of a competent executive are necessary, however, if an extensive program is undertaken. If he is properly qualified and uses good judgment, his advice and guidance can be of considerable value.

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Hawley Speaks His Mind

Whatever it is that gives a man color, Dr. Paul R. Hawley, Chief Medical Director of the Veterans Administration, has it. As head of the medical department of the Administration, he is a dynamic executive who gets things done. In the process, he has stepped on quite a few toes because of his habit of saying just what he thinks. That the subject matter is one which others would deal with circumspectly bothers him not at all. He lays it on the line. Perhaps that is the soldier in him. At any rate, his recent statements about the medical profession have not been to the liking of many of his fellow physicians. They are under the impression that Dr. Hawley is impetuous and that some of his statements are "off the cuff"; that if he had given thought to them, he probably would have couched them in a little different language. Such conclusions, of course, may be erroneous. No doubt, Dr. Hawley himself would take exception to them.

A few weeks ago, Dr. Hawley addressed the annual meeting of the Association of Honorary Consultants to the Army Medical Library. He was quoted in the press as saying that "the number of people in this country who favor the present system of medicine is slight." Among other "Hawleyisms" were: "We've got to take the leadership away from the people of medicine who exploit for dollars." "I believe we have the responsibility for taking the rascals out of medicine, but I do not think we can do it under our present organization any place after the first year in medical school." "We may at any time suffer a revolution in the practice of medicine in this country."

Your Directory Information Card

Preparations are now being made to publish the Eighteenth Edition of the American Medical Directory. The last edition of the Directory was issued late in 1942. Since that time, it has been impossible to publish a new edition because of wartime restrictions and the shortage of paper and labor.

About November 15, a directory card will be mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly whether or not any change has occurred in any of the points on which information is requested. It is urged that those physicians also fill out the right half of the card, which information will be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, mail the card promptly to insure the accurate listing of his name and address. There is no charge for publishing the data nor are physicians obligated in any way.

Should any physician fail to receive one of these Directory Information cards by December 1, he should write at once to the Directory Department requesting a duplicate card be mailed.

When one analyzes these statements, they fall into three categories: they either have no basis in fact, they are misleading, or they are an exaggeration of the truth. For example, Dr. Hawley's observation that only a small minority of people in this country favor the present medical care system cannot be substantiated by facts. When he intimates that commercially-minded doctors have a monopoly on medical leadership, he gives an entirely erroneous impression. Certainly he would not go so far as to suggest that all medical leaders fall in this category, unless he has in mind their opposition to compulsory sickness insurance. If this be true, he is all the more guilty of distortion. Throwing out the "rascals in medicine" is admittedly difficult. Your Observer agrees that they should have been weeded out before they became full-fledged physicians, but who is to do it when they have entered practice? Once they are licensed, only more rigid laws regulating the conduct of physicians will be of value. Nevertheless, this is a problem which should be given thoughtful consideration by the medical profession. More important, something should be done about it. This is not to minimize the effectiveness of the control which medical societies exercise in enforcing their rules of behavior. Thanks to their efforts, medical practice has by and large been maintained on a high plane. As to Dr. Hawley's opinion that we may have a revolution in medical practice, there is nothing new or startling about such a statement. It would receive scant attention if it had been made by anyone else. Of course there will be

(*Continued on page 650*)

The Editors' Forum

TOMORROW'S MEDICAL PRACTICE

HENRY A. DAVIDSON, M.D.

Editor, Journal of the Medical Society of New Jersey

EDITOR'S NOTE: Few medical editors are as well equipped for their task as Dr. Davidson. His gifts as a writer are amply demonstrated by the following article. Whatever one's views may be on the subject about which he writes, here is a stimulating, thoughtful statement.

Even without a crystal ball, the alert practitioner today can forecast the shape of medical practice in the days when the class of 1947 meets for its tenth reunion. By that time prepayment medical care plans will have covered as much of the country as Blue Cross plans do today. But the spread of health insurance will have a far greater effect on the M.D.'s day-by-day routine than did the rising tide of hospital insurance.

In the first place, the doctor will have accustomed himself to far more lay intervention in medical procedures than is today considered possible. For when the bill-paying function passes from the patient to the "company," the latter is going to enforce its right to inspect records and to insist on advance authorization for expensive procedures. While there will be less of this under medical society plans than under commercial insurance, and less of it under voluntary than under compulsory projects, it is naïve to suppose that even medical societies will be able to administer such projects without lay officials. The question "Was this treatment necessary?" or "Was this procedure authorized?" will be asked by the keeper of the purse, and the doctor will answer—or he won't be paid. This may be an undignified position for the practitioner, but it is an inescapable one. Experience shows that health insurance cannot function on the honor system. So the general practitioner, 1957, must be prepared to justify his procedures to a nonprofessional auditor. Either that, or be willing to be on the outside looking in.

A secondary result of this will be the invasion of much of the traditional privacy of medical records. You can't expect the "corporation" to pay you for treating syphilis unless you reveal the name of the patient and the evidence for the diagnosis. Not even a medical-society-sponsored plan is going to pay a doctor for six injections unless his bill indicates what the injections were.

A third result will be increasing importance to medical society membership. Whether the societies themselves sponsor the plans or whether commercial corporations or governmental agencies sit in the driver's seat, the fact will be that membership in a county medical society will become the simplest way of establishing status as a "reputable physician." Note that even today most VA "home-town" contracts still make membership in the medical society the basic requirement for participation.

A fourth change, and probably a good one, will be in the direction of more meticulous record-keeping. The practitioner had better keep a copy of every report and bill he sends out, and of every certificate too. And there will be a plethora of "certificates" in the brave new medical world of tomorrow. And with the need of "supporting" his procedures, the doctor will have to have records which will stand inspection.

In all probability there will have to be some sort of standard nomenclature. How can the company keep statistical records (and in the world of tomorrow the statistician will be a top brass-hat) under the present catch-as-catch-can nomenclature? Is one doctor's "traumatic encephalopathy" the same as another's "concussion syndrome"? Will "hyperthyroidism" be tallied in the same column as "exophthalmic goiter?" The answer inevitably is a single, uniform medical terminology.

As health insurance programs wax, administration will become increasingly complex. At some middle echelon will sit an M.D. (not, we hope, a layman) to check diagnoses and authorize treatments. From his swivel chair, the medical administrator, sincerely trying to maintain top-notch professional standards, will become disturbed at the carelessness with which many physicians make diagnoses. "Chronic gastritis" will be anathema, and "sacroiliac strain" perhaps as obsolete as "the vapors." Then will come a directive—all diagnoses must be supported by objective evidence. The company will not pay for the treatment of epilepsy until an electroencephalogram confirms the diagnosis, and medication for nephritis can scarcely be authorized until the kidney function results have been filed. It will make for scientific accuracy, though it may be a bit hard on the practitioner who depends on his clinical hunches.

The doctor will grumble and gripe, but he will survive. Perhaps his clinical acumen will be sharpened by these more rigid standards. Or maybe not. At least he will get a month's leave every year (more than most of them get now) and he might spend it visiting the Nation's capital. Perhaps in the Smithsonian Institute there, along with the "Spirit of St. Louis" and an old horse-car, he may see the nostalgic outlines of a little black bag.

THE DAVIDSON LECTURER FOR 1947

On October 22, 1947, the Ninth Davidson Lecture was presented by Dr. Oscar H. Fulcher on the subject of "Cranioplasty: A Technic with Tantalum." President Holden presented Dr. Fulcher with the honorarium in the form of a check and a framed certificate. The certificate was awarded this year for the first time.

The Davidson Lecture, which was established in 1929, commemorates the outstanding service rendered to the medical profession in Washington by Dr. Edward Young Davidson, who brought to fulfillment the erection of a building in which to house meeting place and offices of the Medical Society of the District of Columbia. The Lecturer is selected biennially on the basis of competition by a subcommittee of the Executive Board. The subcommittee consisted this year of the following members: Dr. William P. Herbst, Chairman; Drs. William Earl Clark, William M. Ballinger, Fred R. Sanderson and Raymond T. Holden.

The Committee spoke most highly of Dr. Fulcher's essay, which represented his experiences with Marine and Naval personnel, suffering with cranial defects, who were operated during the summer of 1945 at the U. S. Naval Hospital in Oakland, Calif. Additional experiences in the Naval service and in private practice were not included in this paper, Dr. Fulcher commented, but corroborated the results and the conclusions stated.

Oscar H. Fulcher, M.D.

Tantalum was first used to repair cranial defect on November 1, 1941 by Dr. Fulcher, at the suggestion of Captain F. R. Hook, M.C., U.S.N. Another patient was operated, April 15, 1942. These two cases were presented to some neurosurgeons of the Army, who continued with the work.

After Dr. Fulcher returned from overseas, abundant opportunity was offered to repair cranial defects on members of the Marine Corps and Navy who had received wounds to the head. At first the primary reason for repairing the cranial defect was for cosmetic reasons. "Much to our surprise," Dr. Fulcher stated, "repairing the cranial defect once again made the skull a closed organ or cavity and many of the symptoms and signs formerly considered as functional disappeared. As a result of this work, it was ascertained that vertigo headache, impending syncope, and the lack of ability to engage in various exercises could be corrected or eliminated simply by repairing the defect. Thereafter the syndrome and the cranial defect was established on an organic basis and removed from the realm of functional reactions. Many of the Marine and Navy personnel who were thus operated were able to return to full duty and to continue in the combat status."

Much more significant than the monetary award is the distinction of being chosen the Davidson Lecturer. Those who heard Dr. Fulcher's paper read at the first scientific meeting in the Society's building this fall agreed that it was an excellent presentation and a noteworthy contribution to the field of surgery.

Dr. Oscar Hugh Fulcher is Professor of Neurological Surgery at Georgetown University School of Medicine. When he came to Washington to practice in 1937, he was appointed Associate Professor of Clinical Surgery at Georgetown. Four years later, May 1, 1941, he was called to active duty in the Medical Corps of the U. S. Naval Reserve to inaugurate a Department of Neurological Surgery at U. S. Naval Hospital, Washington, D. C., which later was transferred to Bethesda, Md. On July 10, 1942, he was attached to the U. S. Navy Depot at Brooklyn, N. Y., to help establish Mobile Hospital Unit No. 8. This hospital unit was transferred to Guadalcanal in March, 1943, where he was Chief of Neurological Surgery. On January 8, 1944, he was transferred to U. S. Mobile No. 5 (Fleet Hospital No. 5) where he was Chief of Neurological Surgery. He served two years in Guadalcanal and New Caledonia, often flying to other bases for neurological consultation and neurological surgery. He was Chief of Surgery of the Circulatory Nervous System at U. S. Naval Hospital, Oakland, Calif., from February 6 to July 24, 1945, and Chief of Surgery of U. S. Naval Hospital, Long Beach, Calif., from July 28 to date of separation on February 6, 1946, when he was retired to inactive duty with the rank of Captain.

On April 21, 1945, Commander Fulcher was cited by Admiral Nimetz for "distinguishing himself by meritorious conduct in the performance of his duties as Neurosurgeon on the staff of a fleet hospital in the South Pacific area from April 4, 1943 to December 8, 1944."

Dr. Fulcher was born, August 29, 1901, in Sandidges, Virginia. He received his Bachelor of Science degree from the College of William and Mary in 1922, and graduated from the University of Virginia in 1926. He practiced in Berne, Washington, for a year; then was a Fellow in Surgery at the Mayo Clinic from 1928 to 1933. In 1931 he received his Master of Science degree in Surgery from the University of Minnesota. From 1933 to 1937 he was Superintendent and Chief of Staff of the Grace Hospital in Welch, West Virginia.

Following Dr. Fulcher's return to Washington in 1946, he was appointed Acting Professor of Neurological Surgery at Georgetown; he was made full Professor of Neurological Surgery in 1947.

Dr. Fulcher is a Fellow of the American College of Surgeons and the American Medical Association: a diplomate of the American Board of Surgery; and a member of the Washington Academy of Surgery and the Southern Medical Association. He became an Active member of the Medical Society of the District of Columbia in 1937 and this year holds the chairmanship of an important committee, the Committee on Postgraduate Education.

TREATMENT FOR ALCOHOLISM IN WASHINGTON AND THE YALE PLAN

Oscar B. Hunter, M.D., F.A.C.P.

Vice Chairman, Washington Committee for Education on Alcoholism

During the past few months considerable attention has been drawn to the subject of alcoholism, largely due to the efforts of the Washington Committee for Education on Alcoholism, whose existence first attracted wide attention in May of this year when the Committee sponsored an Institute on Alcoholism at the Cosmos Club, and later when the Committee opened its Alcoholic Information Center at 1713 M Street, directly opposite the D. C. Medical Society's headquarters. Appearing concomitantly with publicity accorded the endeavors of this Committee in local newspapers were several releases and editorials on (1) the splendid work being done at the Municipal Court by members of Alcoholics Anonymous, (2) the Alcoholic Clinics operated by the D. C. Health Department at the old Force School Building on Massachusetts Avenue and the Polk Health Center, and (3) the Hebert Bill.

It is no wonder that considerable confusion exists as to these different approaches—where one leaves off and the other begins, or, indeed, if there is any connection between them at all, and it is in an effort to clarify the picture that a brief correlation is presented here of these efforts of modern science toward the solution of the age-old problem of alcoholism, at least in so far as the District of Columbia is concerned.

Alcoholics Anonymous

The first constructive effort in behalf of the alcoholic in the District of Columbia was made when Alcoholics Anonymous established a group in Washington some eight years ago. Alcoholics Anonymous and its work have received a great deal of notice since its founding in 1935. Most people know a little about it, but all too few understand the exact manner of its working. (Literature explaining the program fully may be had for the asking by calling Executive 1964 or writing to the A.A. Club at 1012 H Street, N.W.) Suffice it to say here that its membership is made up of recovered alcoholics who are banded together to help themselves gain and maintain sobriety. To date this group has had the highest percentage rate of success of any existing therapy by overwhelming majority. It has been pointed out that its only weakness lies in the fact perhaps that, as its members are laymen, Alcoholics Anonymous has no way of scientifically screening out the small percentage of "psychotics" from the "straight alcoholics." If this is a weakness in the A.A. program, it is one which might well be considered inconsequential here in the District, as the Washington A.A. group coöperates closely with the now existent Clinic and refers to them any doubtful or unresolved cases for psychiatric treatment.

D. C. Alcoholic Clinic

The next milestone was marked in 1945 when the D. C. Commissioners, inspired by the efforts of a few public-spirited citizens, authorized the integration of an Alcoholic Clinic within the Bureau of Mental Hygiene of the Health Department. As far as can be ascertained this was the first public recognition by a municipality that the disease of alcoholism was a civic responsibility for which clinics should be established as they had been for tuberculosis, cancer, and other diseases.

This Clinic was established on an outpatient basis only. In addition to psychiatric treatment and routine medical examinations, it also boasts of being the first clinic in the United States to utilize the good offices of Alcoholics Anonymous on other than a referral basis. A.A. volunteers are in attendance at all clinic sessions, performing various administrative chores, and specifically, are always ready to introduce any new patients designated by the psychiatrists into the mysteries of the local A.A. Club and its program for rehabilitation. These A.A. volunteers have no official concern with the medical details of the Clinic, have no access to the charts, the histories, or to the medicines, and are not regarded as part of the medical staff of the Clinic. Simply, this is a plan for coöperation and liaison, where one approach often can and does augment the other.

That this Clinic for the last two years has struggled along valiantly under the careful guidance of Dr. Daniel Seckinger, Assistant District Health Officer, and Dr. Leopold Wexberg, Director of the Bureau of

Mental Hygiene, in the face of an ever-increasing demand for its services and the serious handicaps of insufficient funds and limited personnel, would not seem to have been in vain, for now, with the passage of the Hebert Bill, the patience and perseverance of those connected with, and interested in, this Clinic are, at last, to be rewarded.

THE HEBERT BILL

Public Law 347, popularly known as the Hebert Bill (H.R. 2659—80th Congress) because of its authorship and introduction in the House of Representatives by Congressman Hebert of Louisiana, in its interpretation and administration by the D. C. Commissioners, not only promises to provide the financial succor necessary to maintain the already established clinics, but it also promises relief to the Municipal Court, the jail, and the workhouse, which have been overburdened for many years with alcoholic cases.

This Law provides for the medical and scientific treatment of persons found to be alcoholics by the Municipal Court, as well as those residents who wish to submit themselves voluntarily for treatment at the Clinic.

Dr. Waxberg has stated that this new program of clinic expansion, which is to be launched in the near future, will include not only more clinic hours and sorely needed personnel, but also the screening of alcoholics who come into the Municipal Court.

The program will be financed by a 10 per cent additional tax on liquor licenses, which it is estimated will total approximately $75,000 to $100,000. The Commissioners will be aided in their administration of the Law by a special advisory committee composed of six District residents who will reflect different spheres of community thought, including Alcoholics Anonymous.

Obviously, the Hebert Bill is a revolutionary departure from the traditional and ineffectual system of punishing drunks. This recognition by the Federal Government of the alcoholic as a sick person, and the provision of modern, scientific and proper treatment for him or her, augurs well for the attainment of high purposes in the eventual enlightenment of the public as to the true nature of alcoholism and the solution of this vexing and costly problem.

THE WASHINGTON COMMITTEE AND THE YALE PLAN

It is with this enlightenment of the public that the Washington Committee for Education on Alcoholism is chiefly concerned. Whereas Alcoholics Anonymous and the D. C. Alcoholic Clinic augment each other through the coöperative system that they have effected in Washington in their treatment of the alcoholic himself, another important factor must be considered before a true solution can be achieved. That factor is that large group of non-alcoholic citizens, the Public, and the Public's understanding of the problem and how it is affected by the problem. For there is no denying that it does affect them, directly or indirectly, and for too long this has been a taboo subject, something to be mentioned only in whispers, or something to shut our eyes upon.

It is from this group that the National Committee for Education on Alcoholism and its branch, the Washington Committee, hope to gain wide acceptance for its three simple concepts:

1. Alcoholism is a disease and the alcoholic a sick person.
2. The alcoholic can be helped and is worth helping.
3. This is a public health problem and therefore a public responsibility.

When every citizen accepts these concepts, knows the facts about alcoholism, its nature and its treatment, and knows that it is no respecter of persons, then, and only then, will the stigma, which has for so many years been unfairly attached to it, be lifted from alcoholism.

The National Committee for Education on Alcoholism is a division of the Yale Plan on Alcoholism. Starting many years ago with a laboratory for physiologic research with particular emphasis on alcohol, the activity and interest at Yale in the problems of alcohol and alcoholism steadily expanded. Today it is the recognized center of research in these fields. Instead of a laboratory for physiologic research it is now an organization of five major divisions: First, research, not only physiologic, but also historic, psychologic, psychiatric, legal, and sociologic. Second, publications, the Yale group putting out pamphlets, books, scientific monographs, the *Quarterly Journal of Studies on Alcohol*, and others. Third, the Yale Summer School of Alcohol Studies, a five weeks' course on alcohol and alcoholism conducted every summer, attended by persons from every state in the Union as well as from foreign countries. Four, the Yale Plan Clinic, a full-time, outpatient clinic for alcoholics which serves not only as a social and medical resource for its community, but which is also a pilot clinic for other communities, a training center for workers, and a research organization for testing diagnostic and therapeutic technics.

The fifth division of the Yale Plan is the National Committee for Education on Alcoholism, and its affiliated local and state committees. It was felt by the research men, the teachers, and the clinicians that the results of their experience and research would never be of maximum effect until the American public itself became interested, recognized the problem as a public health responsibility, and coöperated with the courts, the medical profession, Alcoholics Anonymous, social workers, and others, so that really effective action could be achieved. The National Committee is deeply interested in the prevention of alcoholism as well as in its alleviation. It feels, however, that prevention is most likely to be achieved not by legal decree, not by exhortation, but by widespread dissemination of scientifically determined facts about alcohol and alcoholism coupled with effective demonstration of the worth of these facts through large scale rehabilitation. This calls for the stimulation and education of the general public, the development of facilities and qualified personnel for adequate rehabilitation, and the enlightened coöperation of many groups and individuals. To attain these ends the National Committee attempts as its major technic to foster the growth of local community groups which will work toward these goals in their own area, with the support and interest of their own neighbors and townspeople.

Standing behind the Washington Committee, then, is a nationally recognized group experienced in and equipped for research, publication, formal education, and therapy. The local committee, in this instance, Washington, plans to promote Community Education, Community Integration and Community Action in relation to problems of alcoholism. It should be clearly understood that the Committee is not a therapeutic or rehabilitation center or service itself. Unlike Alcoholics Anonymous its major function is not the rehabilitation of individual alcoholics. Rather are its purposes the education of the general public, the stimulation of groups and institutions who though presently not helping the alcoholic, could and should do so, the collection of information about the problem and about available resources to meet that problem within the community, and the dissemination of information both to those who need aid directly and to those who would desire more economic and more effective means for coping with this great social and medical problem.

As a branch Committee and a part of the experienced, organized, and active Yale Plan on Alcoholism, the Washington Committee faces a grave responsibility, and a challenge which cannot be denied.

In accepting this challenge, that same small group of citizens who, inspired by the Yale Plan, had urged the Commissioners authorization of the clinic in 1945, united to form the nucleus of the Washington Committee.

In addition to the inauguration of a comprehensive program of education and general enlightenment, the Committee operates an Alcoholic Information Center as a service to the city. While this is neither a diagnostic nor treatment center, it serves as a counseling center where anyone may come for information on the subject, or for direction to the various treatments for alcoholism or such hospitalization facilities as do exist. If the medical man will utilize this service, not only will he start the alcoholic along the road to rehabilitation, but he will relieve himself of a patient who seemingly is not only uncoöperative, but a purely vexatious and insoluble problem.

Likewise the medical man can be of inestimable value in the stimulation of interest and the promotion of adequate hospitalization facilities for the treatment of alcoholics. To date, Gallinger Hospital has borne the whole burden, and a pressure has been put upon it which, with totally insufficient number of beds, it has been unable to meet.

If we are adequately to meet the challenge which we have accepted, the Washington Committee must have the understanding and support of the medical profession, and particularly the general practitioner to whom so many people turn for information and advice on matters of health. The doctor can be the leader in the educational field on this subject, as well as the practitioner in actual cases. He can do more to change the prevalent attitude into a sympathetic one, based on scientific facts, than any other group, if he will.

Washington Physicians of Yesterday

EDWARD OLIVER BELT, M.D.

Appalling tragedy brought to an untimely end the outstanding career of Dr. Edward Oliver Belt, who in his time was one of the leading ophthalmologists of the city of Washington.

Born May 19, 1861, at Rock Hall, Frederick County, Maryland, and derived from a distinguished old Maryland family, Dr. Belt obtained the degree of M.D. from the University of Maryland in 1886. After practicing medicine for a few months in Frederick County, he served for two years as resident physician at the Presbyterian Eye, Ear and Throat Hospital in Baltimore. He then studied ophthalmology and otology at the University of Vienna, and hospitals of Paris, Berlin, and London. He next took a postgraduate course in histology and pathology at Johns Hopkins University, and was visiting surgeon to the above-mentioned Presbyterian Hospital.

In October, 1889, he removed to Washington, where for the remainder of his life he practiced his specialty with ability, success, and distinction. He was Professor of Ophthalmology and Otology at Howard University Medical School from 1890; Ophthalmologist and Otologist to Freedmen's Hospital in Washington, and to the Baltimore and Ohio Railroad, and consultant to the City and Emergency Hospitals of Frederick, Maryland.

Dr. Belt was the originator and a founder of the Episcopal Eye, Ear and Throat Hospital of Washington, D. C. The first conference on the establishment of this hospital took place in his office on May 25, 1896; the hospital was opened April 8, 1897, at the southwest corner of Seventeenth and L Streets, N. W., and in May, 1904, moved to a new building constructed at its present location at 1147 Fifteenth Street, N. W. Dr. Belt was untiring and unselfish in his devotion and energy to this institution, serving it as Surgeon, member of its Board of Directors, Secretary, and Executive Officer; and it abides as a monument to his memory and achievements.

(*Continued on page 650*)

CONTROL OF INTERFERENCE CAUSED BY DIATHERMY EQUIPMENT

More than ten years ago the Federal Communications Commission was requested by radio communication agencies to formulate regulations to control the interference caused by diathermy equipment. On May 9, 1947 the Commission released Public Notice no. 7722, which document assigned three frequency channels, all in harmonic relationship with one another, for medical diathermy. The channels are 13.66, 27.33 and 40.98 megacycles, corresponding to approximately 22, 11 and 7½ meters wavelength, respectively. The widths of the channels are approximately 15, 320 and 40 kilocycles. Radiations from frequencies other than those specified shall be suppressed so that radiation does not exceed a strength of 25 microvolts per meter, at a distance of a thousand feet or more from the diathermy equipment causing such radiation. The Commission pointed out two methods for operating diathermy apparatus in order to comply with these rules for equipment manufactured after July 1, 1947. The first method is to operate within assigned frequency bands using equipment either "type approved" or certified by a competent engineer. The second method is to operate on any frequency, provided the equipment is enclosed in a shielded room with a filtered power supply and that all radiation on any frequency is limited to 15 microvolts per meter at a distance of 1,000 feet or more from the diathermy equipment. Operation in this manner also requires certification by a competent engineer. A physician owning and operating a diathermy apparatus manufactured prior to July 1, 1947 may continue to operate for a period of five years, provided the equipment does not interfere with authorized radio services. If interference is reported, the physician is responsible for eliminating the disturbance to radio communications. This may be accomplished in some instances by readjusting the existing diathermy appliance. If no means can be provided to eliminate the interference, the physician becomes subject to the new rules and regulations. That is, he must screen his present apparatus or acquire frequency controlled equipment. The channel 2,450 megacycles has been assigned, corresponding roughly to 12.2 cm. wave length. A channel in the neighborhood of 6 megacycles will be announced later. Frequencies of 915, 5,850, 10,600 and 18,000 megacycles have also been allocated for industrial, scientific and medical use. At present the Commission has not found it necessary to make any rules applicable to surgical diathermy. The medical profession and the manufacturers of diathermy are to be congratulated on the successful coöperation with the Federal Communications Commission and the representatives of radio industries on reaching a solution of this perplexing problem in the field of radio communications and diathermy.—*Reprinted from Current Comment, J.A.M.A.*, 1947, **134,** 1486.

The Federal Communications Commission announced on October 20, 1947 (Public Notice 13433) that Certificates of Type Approval have been issued to the following manufacturers for specific models:

Manufacturer	*Type or Model*	*FCC Type Approval No.*
Burdick Corporation	X-85	D-471
The Liebel-Flarsheim Company	SW-227	D-472
Raytheon Manufacturing Co.	CMT-4 Microtherm	D-473
Birtcher Corporation	800	D-474
World-Wide Electronics, Inc.	FCP (Portable)	D-475
Terma Electric Company, Inc.	FC 550	D-476

Part 18 of the Rules relating to Industrial, Scientific and Medical Service, which became effective on July 1, 1947, establishes procedures and standards for the issuance of type approval certificates for diathermy equipment.

Manufacturers may submit equipment to the Commission for tests to ascertain whether such equipment meets the requirements of the Rules. Two of the major requirements involve the reduction of harmonic and spurious emissions to specified limits and operation within assigned frequency bands. Manufacturers of equipment meeting the requirements of the Rules are issued Certificates of Type Approval for identical equipment. Each type-approved equipment must have associated with it a dated certificate or nameplate setting forth the FCC type approval number and other data required by the Rules.

Type approval constitutes a reasonable assurance that under normal circumstances objectionable interference to other radio services will not occur.

MEETINGS

Wednesday, December 3

Speakers and subjects to be announced.

Wednesday, December 10

The District of Columbia Pharmaceutical Association will sponsor the program. Speakers and subjects to be announced.

News and Personals

The American Academy of Allergy will hold its annual convention at Hotel Jefferson, St. Louis, Missouri, December 15–17. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy, without payment of fee. Round table conferences will be held on Monday afternoon, December 15. Advance copies of the program may be obtained by writing to the Chairman on Arrangements, Dr. Charles H. Eyermann, 634 North Grand Boulevard, St. Louis, Mo.

The National Gastroenterological Association again announces its **Annual Cash Prize Award Contest for 1948.** A check for $100 and a Certificate of Merit will be given for the best unpublished contribution on gastroenterology or allied subjects. Contestants residing in the United States must be members of the American Medical Association. The Association reserves the exclusive right to publish the winning contribution, and those receiving certificates of merit, in its official publication, *Review of Gastroenterology.*

All entries should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, and addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y. Entries must be received not later than April 1, 1948.

The American Urological Association offers a total annual award of $1,000 for essays on the result of some clinical or laboratory research in urology. The awards will be distributed as follows: first prize, $500; second prize, $300; and third prize, $200. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals. The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Boston, May 17–20, 1948. All papers must be submitted to the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tenn., before March 1, 1948. Dr. Moore will gladly supply full particulars about the contest upon request.

CALENDAR OF MEETINGS

October 2	Joint meeting of Medical Service and Section on Ophthalmology, Otology, Rhinology and Laryngology
	Section on Neurology and Psychiatry
October 4	Washington School of Psychiatry
October 5	American College of Chest Physicians
October 8	Woman's Auxiliary to the Medical Society of the District of Columbia
October 11	Washington Psychoanalytic Society
October 13	Washington Orthopedic Club
October 14	District Dental Society
	Registered X-Ray Technicians of Washington
October 15	Washington Diabetes Association, Inc.
October 20	District Selective Service Association
October 21	Subcommittee on Tuberculosis
	D. C. Medical Technologists
October 22	Scientific Meeting of Medical Society
October 23	Graduate Nurses' Association
October 25	Graduate Nurses' Association
October 27	Executive Board
	Committee on Postgraduate Education
October 28	Classification Committee
October 29	Scientific Meeting of Medical Society
	Committee on Medical Care
October 30	D. C. Rheumatism Society

To assure the listing of all outstanding medical and surgical motion picture films in the revised **Catalogue of Professional Motion Picture Films** now being compiled by the Academy-International of Medicine, all film authors are urgently requested to write for film questionnaires to be filled out and returned immediately. Members of the medical profession are invited to forward this announcement to an author, or to furnish the film title and full name and address of any film author to the Academy-International of Medicine, 214 West Sixth Street, Topeka, Kansas.

Dr. Richard B. Cattell will address the **Silver Spring Academy of Medicine,** December 1. His subject will be "Pancreatic Surgery." Dr. Charles Stanley White will lead the discussion.

The Executive Board, at its meeting, September 22, confirmed President Holden's appointment of Dr. Luther Gray as Chairman of the Medical Division of the Community Fund Campaign and the appointment of Dr. George L. Nordlinger to the Medical Bureau Committee.

A new Committee on Rehabilitation was also created, to which Dr. Holden appointed the following members with the approval of the Board: Dr. Walter H. Gerwig, Chairman; Drs. Isidore Lattman, Bernard J. Walsh and William J. Tobin.

The Philadelphia, Baltimore and Washington Neurological Societies held their annual Tri-City meeting at the Barclay Hotel, Philadelphia, October 24. The following papers were presented by Philadelphia physicians: "Pick's Disease," Dr. N. W. Winkelman; "Vascular Tumors of the Spinal Cord," Drs. Joseph C. Yaskin and Charles I. Oller; "Physiological Studies in Arteriovenous Anomalies of the Brain," Dr. Henry A. Shenkin et al; and "Aneurysms of the Posterior Communicating Artery," Dr. R. Jaeger. Dr. Paul R. Hawley, Chief Medical Director of Veterans Administration, spoke on the VA program in the field of psychiatry and neurology. About 30 physicians from Washington attended the meeting.

The D. C. Rheumatism Society held a meeting, October 30, in the Medical Society's building. Dr. Edward C. Reifenstein, Jr., Director of the Sloan Kettering Institute of New York, was present to speak on "Osteoporosis."

A series of postgraduate courses in psychiatry and neurology is in progress at **St. Elizabeths Hospital,** continuing from September 29, 1947 to June 11, 1948. The lectures are held at the Blackburn Laboratory. Information regarding the courses may be secured from Dr. S. Katzenelbogen, telephone Lincoln 1424, Extension 62.

The Society of Registered X-ray Technicians will hold its regular monthly meeting, December 9, at 8 p.m., in the Medical Society's Library. Persons engaged in any phase of X-ray work are invited to attend.

The first fall meeting of the **George Washington University Medical Society** was held on October 18. Dr. Lloyd G. Lewis, Associate Professor of Urology at Georgetown University School of Medicine, presented a paper on "Hematuria." The paper was discussed from the viewpoints of internal medicine, gynecology, radiology, and pathology, by Drs. Paul F. Dickens, J. K. Cromer, Fred O. Coe and Roger M. Choisser, respectively.

The first meeting of the **Clinico-Pathological Society** was held on October 21 at the home of Dr. James N. Greear, Jr. Two case reports were given: "Nephritis" by Dr. William P. Herbst, and "Retropharyngeal Abscess" by Dr. Daniel B. Moffett.

Dr. Wallace M. Yater, Editor of the MEDICAL ANNALS, **Theodore Wiprud,** Secretary of the Medical Society and Managing Editor of the ANNALS, and **J. Richard Connelly,** Assistant Secretary of the Society, attended the annual **Secretaries and Editors Conference** at AMA Headquarters in Chicago, November 7 and 8. Mr. Wiprud was Chairman of the Committee on Arrangements for the Conference.

All officers of the **District Division of the American Cancer Society** were reëlected at the Society's first annual meeting, October 8. They are:

Dr. Harry H. Kerr, *President;* Eliot Wadsworth, *Vice President;* Dr. Calvin T. Klopp, *Secretary;* and Frederick P. H. Siddons, *Treasurer.*

Officers will serve as the Executive Committee, with Dr. Murray M. Copeland as a fifth member.

Federal Security Agency announces that funds allotted by the U. S. Public Health Service for basic medical research have totalled $10,214,174 during the past 20 months. A total of 629 scientists and

193 institutions have shared in these grants, with the District of Columbia well represented. From January 1, 1946 to August 31, 1947, the following institutions have shared in the research projects to the amount indicated:

American Academy of Pediatrics	$231,400
Carnegie Institute	7,546
Children's Hospital	17,088
Georgetown University	30,212
George Washington University	51,824
Howard University	4,684
National Research Council	27,000
St. Elizabeths Hospital	3,586
Warwick Memorial Clinic	25,747
Washington School of Psychiatry	13,850
Total	$412,937

A number of Washington ophthalmologists and otolaryngologists participated in the scientific program of the **American Academy of Ophthalmology and Otolaryngology** during its 52nd annual session in Chicago, October 12 to 17.

On the teaching staff for a special Section on Instruction conducted by the Academy were Drs. Frank D. Costenbader, Ernest A. W. Sheppard, Benjamin Rones, M. Noel Stow, James N. Greear, Jr., and G. Victor Simpson. Dr. Sheppard spoke on "Fusion" and Dr. Costenbader on "Orthoptics in Children" during a course designated Orthoptics. Drs. Rones and Stow presented a course on Clinical Pathology; Dr. Greear, one on Rehabilitation of the Blind; and Dr. Simpson, The Treatment of Myopia —Glasses and Medical Adjuncts.

Dr. David Davis read a paper on "Penicillin Aerosol" before the Section on Otolaryngology, October 14. Dr. Rones discussed a paper on cataract extractions, October 16.

Dr. Costenbader was elected Secretary-Treasurer of the American Orthoptic Council.

Miss Dorothy Bair, Dr. Costenbader's technician, was reëlected President of the American Association of Orthoptic Technicians, which held meetings in conjunction with the Academy. On October 12, Dr. Costenbader addressed the Association on "Aids to Ocular Examination of Children."

Dr. Sheppard remained in Chicago following the meetings of the Academy to deliver two additional lectures at Children's Memorial Hospital, where he spoke on infra-nuclear paralysis and on the evaluation of tests for ocular-motor imbalances.

Two innovations have been reported at **Gallinger Municipal Hospital** by **Dr. Alvin R. Sweeney,** Superintendent. The first is the opening of a medical outpatient clinic under the direction of **Dr. Joseph T. Roberts,** Chief Medical Officer. The clinic is now accepting only cardiac and diabetic cases which have been under treatment in the Hospital, but the services may be expanded to include all general medical cases as well as new patients.

Physicians are provided from the resident staff of the Hospital and from the visiting staffs of Georgetown and George Washington University Schools of Medicine. Clinic hours for George Washington doctors are from 8:30 to 11 a.m. Tuesdays, and the same hours on Wednesdays for Georgetown physicians.

The second innovation concerns the interns at the Hospital, who will serve two years beginning next July instead of one year as at present. The emphasis of the new system will be toward specialization, Dr. Sweeney says, with general practice training available for those who wish to enter that field. Internships will be divided into three classes—surgery, internal medicine, and general practice. Under the current program, doctors are given courses in each branch of medicine.

Until now, interns had to transfer to another hospital for further training. Dr. Sweeney believes the new system will offer sufficient study in all fields of medicine so that interns will not have to go to another hospital after they finish their two years of training. There will be no increase in the number of interns. The 43 interns now there will be released under a staggered program, to be replaced by new ones.

Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, headed the list of five winners of the second annual Lasker Awards which were formally presented to the recipients in Atlantic City, October 9, during the 75th annual meeting of the American Public Health Association. The funds are provided by the Albert and Mary Lasker Foundation.

Dr. Parran, who was awarded $2,500, was honored for "outstanding contributions to the national health and the World Health Organization," and was especially cited for his efforts to eradicate venereal disease by Federal grants-in-aid to the states and by promoting the establishment of rapid treatment clinics throughout the country. Dr. Parran also received a gold statuette of the Winged Victory of Samothrace, symbolizing victory over disease and death.

Four other winners of the Lasker Awards received $1,000 each. They were:

Dr. Oswald T. Avery, of the Rockefeller Institute for Medical Research, for studies of bacteria which have helped reduce the death rate for pneumonia and other respiratory diseases.

Dr. Thomas Francis, Jr., of the University of Michigan School of Public Health, for isolation of the B influenza virus and for helping develop a vaccine effective against both A and B influenza.

Dr. Homer Smith of the New York University College of Medicine, for investigations in the field of heart disease.

Dr. Alice Hamilton, Hadlyme, Conn., who was cited for a life of research in the prevention of occupational diseases.

In addition to the individual scientists honored by the Public Health Association, the British Ministries of Food and Health, and the United States Committee on Joint Causes of Death received Lasker Group Awards.

William E. Leahy has been named Chairman of the **Washington Chest X-ray Campaign,** which will get under way early in 1948. Mr. Leahy is a well known lawyer, and former Director of the District Selective Service System. The X-ray Campaign is a coöperative project of the District Health Department, the U. S. Public Health Service, and the District Tuberculosis Association, and will be one of the most important steps in the District's tuberculosis control program, toward which Congress has appropriated $66,000.

Dr. A. C. Christie, Washington roentgenologist for almost 40 years, will be in charge of the medical work connected with the local tuberculosis survey. Dr. Christie is a former president of the District Medical Society, the American Roentgen Ray Society, and the American College of Radiology. He was President of the Fifth International Congress of Radiology, held in Chicago in 1937.

Dr. Paul B. Magnuson has been appointed Chief of Professional Services at **Veterans Administration,** succeeding Brigadier General Elliott C. Cutler, who died August 16, 1947. Dr. Magnuson, formerly Professor of Surgery and Chairman of the Department of Bone and Joint Surgery at Northwestern University School of Medicine, has been affiliated with Veterans Administration since November 1945, when he came to assist Dr. Paul R. Hawley, Chief Medical Director, in reorganizing medical care for veterans.

Dr. Edward Harvey Cushing, former Associate Clinical Professor of Medicine at Western Reserve University, Cleveland, will succeed Dr. Magnuson as Chief of the Research and Education Service. Dr. Cushing has been associated with Dr. Magnuson since July 1946 as Chief of the Education Division.

Dr. George P. Robb, Assistant Medical Director of the Metropolitan Life Insurance Company, has supervised the development of a new research center at **Mount Alto Hospital** for the purpose of conducting intensive research into heart disease. The new center will provide postgraduate study and resident training to prepare VA doctors for certification by the American Board of Internal Medicine.

Dr. Robb will continue as consultant to the cardiovascular research unit. He is now consultant in cardiology to the Secretary of National Defense. During World War II he was chief of the cardiovascular and electrocardiographic departments at Walter Reed General Hospital.

Several Washington physicians participated in the program of the 33rd Annual Clinical Congress of the **American College of Surgeons** during its meeting in New York, September 8–12. Dr. Brian B. Blades collaborated in a panel discussion on "Surgery of Pulmonary Infections," September 8. Dr. G. Foard McGinnes took part in a symposium on "The Proper Use of Blood and Blood Plasma," September 9. Dr. Lloyd H. Mousel was moderator for a panel discussion on "Anesthesia for Ear, Nose and Throat Surgery," September 11.

Dr. William S. McCune and Dr. Jacob J. Weinstein participated in a Forum on Fundamental Surgical Problems. "War Wounds of the Rectum and Anal Sphincter" was the subject of Dr. McCune's paper; Dr. Weinstein spoke on "Intravenous, Subcutaneous and Rapid Intramuscular Infusions of Protein Hydrolysate."

Health Officer George C. Ruhland has appointed a committee of six members to advise the Health Department on the establishment of a **clinic for alcoholics.** These members, who have been approved by the District Commissioners, are Donald Clemmer, Director of the District Department of Corrections; Municipal Judge Walter J. Casey; Mrs. George C. Thorpe; the Reverend Dr. Seth Brooks; Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital; and Colonel E. Goring Bliss, of the Chesapeake and Potomac Telephone Company.

The city now operates an alcoholic clinic on a part-time basis, but legislation authorizing establishment of a full-time clinic was approved at the last session of Congress.

The Board of Honorary Consultants to the Surgeon General of the Navy, Rear Admiral Clifford A. Swanson, has been augmented by the appointment of two new members, Dr. Edward L. Bortz, President of the American Medical Association, and Dr. R. L. Sensenich, President-elect of the AMA.

Dr. Charles Sheard, of the Mayo Clinic, and Robert P. Fischelis, Secretary of the American Pharmaceutical Association, are new appointees who will serve as honorary consultants on administration for the new Navy Medical Service Corps.

Dr. J. Winthrop Peabody was one of the instructors at the Second Annual Postgraduate Course in Diseases of the Chest, which was sponsored by the American College of Chest Physicians in Chicago, September 15–20. Dr. Peabody is Chairman of the Council on Postgraduate Medical Education. After leaving Chicago, he visited Grand Rapids, Mich., where he was guest speaker at a joint meeting of the Michigan Chapter of the American College of Chest Physicians and the Michigan State Medical Society, September 23.

On November 22, 1947, the Board of Regents of the American College of Chest Physicians, of which Dr. Peabody is a member, will hold a business meeting at the Hotel Statler in Washington. General S. U. Marietta, President of the College, will preside. On the preceding day, November 21, the College will hold both written and oral examinations for Fellowships in the Medical Society's building.

Three Medical Society members were among the faculty of George Washington University who were honored at the Alumni Association's annual luncheon at the Mayflower Hotel, November 1. They were **Dr. Roger M. Choisser,** Professor of Pathology, **Dr. Preston A. McLendon,** Professor of Pediatrics, and **Dr. John Minor,** Clinical Associate in Medicine. All had completed 25 years of teaching service at the University.

Dr. Jacob J. Weinstein gave three lectures at the James Buchanan Brady Urological Institute of the Johns Hopkins Hospital, September 7, 13, and 20. The papers were entitled, "Protein Metabolism in Surgery and Parenteral Protein Therapy," "Fluid Balance in Surgery—Diagnosis and Management," and "Development and Use of Blood Derivatives in Surgery."

Dr. Daniel Blain, Chief of the Neuropsychiatry Division of Veterans Administration, and **Dr. Norman Q. Brill,** Professor of Neurology, Georgetown University School of Medicine, participated in a round table discussion on "What Is Wrong in Modern Psychiatry?" at the Georgetown University Forum of the Air, which was broadcast October 12 over WARL.

Dr. James W. Love read a paper on "False Positive Serological Tests" before the Medical Society of Virginia, October 13. Discussion of his paper was led by **Dr. E. E. Barksdale.**

A three-day conference held jointly by the **Pan American Homeopathic Medical Congress and the Southern Homeopathic Medical Association** convened in Washington, October 2, 3 and 4. At noon, October 4, doctors attending the Congress gathered at Scott Circle before the statue erected in honor of Samuel Christian Friedrich Hahnemann, early 19th century German physician, to whom modern homeopathic medicine owes its original principles. **Dr. J. B. Gregg Curtis** was master of ceremonies at this concluding event.

Dr. Robert M. Bolton writes from California that he has purchased a home in San Jose and will remain there for an indefinite period. His address is 56 North Cragmont Avenue. Dr. Bolton served over five years in the Medical Corps of the United States Naval Reserve, holding the rank of Captain when he was retired in August 1946. He does not plan to resume active practice for some time.

Dr. Lawrence E. Putnam, Acting Medical Director of the Food and Drug Administration, addressed a luncheon meeting of the biological science group of the Special Libraries' Association, October 4. Dr. Putnam's talk on penicillin was broadcast over radio station WOOK.

Dr. James A. Gannon addressed the Convention of the American Transit Association, October 8, in Atlantic City, on what constitutes a good medical witness.

Dr. S. Ross Taggart, head of the Health Department's Bureau of Venereal Diseases, was elected a member of the Executive Board of the District Social Hygiene Society, October 9.

Miss Ashby Taylor, a member of the nursing staff of **Children's Hospital** since 1926, and Superintendent of Nurses for the last 13 years, has retired from her duties. Succeeding her is Miss S. Kathryn Witmer, formerly Director of Nurses at Milford Memorial Hospital in Milford, Del. As President of the Graduate Nurses' Association, Miss Taylor will maintain her interest in the field of nursing.

Following the resignation of **Mr. Ernest S. Griffith** as President of the **Council of Social Agencies, Miss Jane Hoey,** First Vice President of the Council's Board of Directors, was named Acting President, October 8. Mr. Griffith, who resigned due to pressure of work, is Director of the Legislative Reference Section of the Library of Congress. He has been President of the Council since June of 1944.

Christmas Dinner Dance

sponsored by the

Woman's Auxiliary to the Medical Society of the District of Columbia

MAYFLOWER HOTEL 7:30 p.m. DECEMBER 17, 1947

A Social Event for Everyone

Make New Acquaintances and Renew Old Ones

Good Food *Excellent Music* *Loads of Fun*

MAKE YOUR RESERVATIONS *NOW*

Price per ticket, $5. Make your checks payable to the Woman's Auxiliary to the Medical Society of the District of Columbia and mail to Mrs. Wm. P. Herbst, 2425 Foxhall Road, N. W., not later than December 1.

MEMBERSHIP

The following applicants for membership will be voted on at the meeting of the Executive Board, December 29, 1947:

For Active Membership

Joseph Abrahams, Emory University—1939
Robert Harmon Armstrong, Jr., George Washington University—1943
Harry Clark Bates, Jr., George Washington University—1943
Roland Essig Bieren, University of Maryland—1936
Daniel Blain, Vanderbilt University—1929
Irving Benjamin Brick, George Washington University—1941
Murray M. Copeland, Johns Hopkins University—1927
James Melvin Corcoran, Georgetown University—1942
Ernest Edwin Cornelsen, University of Oklahoma—1943
Leslie Van Dyke Dill, Duke University—1936
Samuel Dove, George Washington University—1943
Robert Frederick Dow, Georgetown University—1934
Thomas Joseph Dugan, Jr., George Washington University—1936
Wilfred Walter Eastman, College of Medical Evangelists—1940
John Robert Egan, Duke University—1942
Alban W. Eger, University of Buffalo—1942
Otto Anderson Engh, Temple University—1933
William James Fink, George Washington University—1944
Charles F. Geschickter, Johns Hopkins University—1927
Herbert Dudley Glick, University of Cincinnati—1934
Louis Goldstein, University of Cincinnati—1936
Theodore August Guenther, University of Michigan—1940
Robert C. Hecker, University of Illinois—1938
Montgomery Earle Higgins, George Washington University—1904
T. Wiley Hodges, Baylor University—1937
Robert Clarence Hunt, George Washington University—1945
Vita Rebecca Jaffe, University of Maryland—1941
Paul Franz Jaquet, Jr., Georgetown University—1943
Leslie Melrose Jones, University of Western Ontario—1917
Sol Katz, Georgetown University—1939
Paul Chapman Kiernan, George Washington University—1937
Seruch Titus Kimble, Jr., George Washington University—1944
Morris Kleinerman, University of St. Andrews—1933
August Kramm, Georgetown University—1940
Henry P. Laughlin, Temple University—1941
Oscar Legault, New York University—1939
Albert Slocomb MacMillan, University of Virginia—1942
Andrew Anthony Marchetti, Johns Hopkins University—1928
Charles Goodsell McCormack, Washington University, St. Louis—1925
James Jerry McFarland, Jr., University of Tennessee—1938
Charles Vivian Pate, University of Georgia—1943
Walter Raab, University of Vienna—1936
Sanford Jay Randall, New York Medical College—1942
Marion Ballard Richmond, University of Maryland—1941
Alexander L. Russell, St. Louis University—1942
Thomas Stone Sappington, Harvard University—1941
Mary K. L. Sartwell, George Washington University—1944
Luther Sheldon, Jr., University of Michigan—1909
Robert Shaw Smith, George Washington University—1943
William Thornton Spence, Duke University—1936
Philip Pendleton Steptoe, University of Virginia—1938
Ralph Stiller, New York University—1940
Raymond John Terrafranca, Georgetown University—1941
William Edward Torrey, Jr., University of Pennsylvania—1943
Edward B. Tuohy, University of Pennsylvania—1932
Merton Theodore Waite, University of Maryland—1940
Howard L. Weinstein, University of Vienna—1936
Edwin Hylan Weitzen, George Washington University—1943
Theodore Winship, University of Nebraska—1937
Theresa Ting Woo, University of Michigan—1934

For Associate Membership

John Marion Bankhead, University of Maryland—1927
William Paul Briggs, Ph.G., George Washington University—1927
Arden Freer, New York University—1913
Grace Hughes Guin, Vanderbilt University—1943
Harry A. Horstman, Jr., Georgetown University—1942
Harold C. Kinner, Ph.G., George Washington University—1928
Howard Robert Lawrence, University of Buffalo—1935
Peter Noble Lombard, Georgetown University—1941
George Branch Patrick, Jr., University of Pennsylvania—1942
Dina Braude Rappaport, University of Illinois—1943
Henry Rappaport, University of Vienna—1937
Mario Scandiffio, George Washington University—1928
George Speck, George Washington University—1941
Roy Elmer Whitehead, Indiana University—1920

BOOK REVIEWS

Surgery of the Ambulatory Patient, 2nd ed. L. Kraeer Ferguson, A.B., M.D., F.A.C.S., Professor of Surgery, Graduate School of the University of Pennsylvania; Professor of Surgery, Woman's Medical College of Pennsylvania; Surgeon, Graduate Hospital of the University of Pennsylvania, Women's Medical College Hospital, Philadelphia General Hospital and Doctors Hospital; Consulting Surgeon, U. S. Naval Hospital; formerly Chief of the Surgical Outpatient Department, Hospital of the University of Pennsylvania; formerly Chief of the Proctologic Clinic, Hospital of the University of Pennsylvania and Philadelphia General Hospital, with Section on Fractures by Louis Kaplan, A.B., M.D., F.A.C.S., Associate in Surgery, University of Pennsylvania; Chief of Surgical Service II, Mt. Sinai Hospital; in charge of the Fracture Division of the Surgical Outpatient Department, Hospital of the University of Pennsylvania. Price

$10.00. Pp. 932, with 645 illustrations. Philadelphia: Lippincott, 1947.

A major part of minor surgical procedures in both rural and cosmospolitan areas are performed by the general practitioners. Therefore, a comprehensive presentation of the common as well as the rare minor surgical lesions which includes diagnosis, pathology, medical management and detailed surgical technics for eradication is a book for the office of all practicing physicians. The clinical practice of general also includes minor surgery, hence this text is a ready source of reference.

The reviewer has found this book to be an integral part of his office library.

Three major sections are included in the text. The first is entitled "Surgical Principles and Lesions" and describes instruments, equipment, technics for various types of local anesthesia, dressings for individual parts, and the treatment of inflammation due to infection by local therapy, chemotherapy and the use of penicillin. Unfortunately, the more recent developments of other antibiotics are not described. However, this was no doubt due to the time required and the inherent difficulties associated with the writing and publication of scientific texts. This same section presents discussions of superficial lesions and superficial cysts or tumors.

The entire volume is profusely illustrated by photographs and line or two-tone drawings of anatomy, pathology, clinical appearance of lesions, and operative technics. In all, there are 645 figures. An interesting innovation in publication method is the inclusion of the illustrations in the index with the use of Italic numerals to indicate illustrations and legends on the page to which reference is made as opposed to Roman type numerals for index materials.

"Surgical Lesions as Applied to Regions of the Body" is presented with clarity and precision in Part II. Throughout this portion of the book there is an orderly description of each lesion by the following plan: Etiology, Diagnosis, Symptoms, Pathology, and Treatment.

Dr. L. Kaplan has written Part III on fractures. The simpler orthopedic problems which are amenable to office management are covered in detail, whereas only a glossary presentation is given for those fractures which require hospital care and specialized treatment.

A valuable assistance to the reader of this book is the bibliography of references for more complete offerings on different aspects of each surgical lesion.

"Surgery of the Ambulatory Patient" by Dr. L. K. Ferguson is a scholarly presentation of diagnosis and treatment of minor surgical maladies and is of value to the general practitioner, internist, and surgeon alike.

JACOB J. WEINSTEIN, M.D.

A History of the American Medical Association 1847–1947. MORRIS FISHBEIN, M.D., with the Biographies of the Presidents of the Association by WALTER L. BIERRING, M.D., and with Histories of the Publications, Councils, Bureaus, and Other Official Bodies. Price, $10.00. Pp. 1226. Philadelphia: Saunders, 1947.

In this swiftly moving, spirited book, milestones in the existence of the American Medical Association pass in review. Published in recognition of the 100th anniversary of the Association, celebrated at the Centennial Session in Atlantic City in June, 1937, this volume was written for a general audience as well as for the medical profession. Physicians will find the historical account written by Dr. Morris Fishbein of special interest, particularly that portion which deals with the now famous anti-trust suit and the controversy over compulsory sickness insurance. Campaigns to raise standards of medical education, to eliminate quackery, to improve industrial health, and to eliminate nostrums and frauds in the medical field provide informative and interesting reading.

Dr. Fishbein demonstrates again in this volume his tremendous capacity for correlating facts and presenting them in a crisp, readable manner.

Dr. Walter L. Bierring is the author of the biographies of Past Presidents of the American Medical Association which are included in this book. They will prove valuable source material.

This book deserves a place in the library of every physician.

T. W.

The Internal Fixation of Fractures. CHARLES SCOTT VENABLE, M.D., F.A.C.S., Diplomate, American Board of Surgery; member, Fracture Committee of the American College of Surgeons, American Academy of Orthopedic Surgeons, Southern Surgical Association, American Association for the Surgery of Trauma, and Texas Surgical Society, AND WALTER GOODLOE STUCK, M.D., M.S. (Orth. Surg.), F.A.C.S., Diplomate, American Board of Orthopedic Surgery; member, Fracture Committee of American Academy of Orthopedic Surgeons, Southern Surgical Association, American Orthopedic Association, American Association for the Surgery of Trauma, and Texas Surgical Society, with a Foreword by RALPH K. GHORMLEY, M.D., F.A.C.S., Professor, Orthopedic Surgery, Mayo Foundation; Consultant, Orthopedic Surgery, Mayo Clinic; Consultant, Orthopedic Surgery, Veterans Administration. Price $5.50. Pp. 241, with 84 figures. Springfield, Ill.: Thomas, 1947.

The authors have presented a subject which has been widely discussed for several years past, and is still quite controversial in the minds of many contemporary orthopedists, in a complete, concise and thoroughly interesting manner. They deal first with a history of the uses of metal appliances, which is not only interesting from a purely historical point of view but is also educational in that the causes of early failures are pointed out.

The experimental work done and the body reactions to practically every known metal is very thorough and leads to definite conclusions as to the relative merits of each, and what should be expected from their use.

The chapters on "Technique on Internal Fixation" and "Fractures of Upper and Lower Extremities" are of value to all physicians and surgeons as they give an excellent idea as to how fractures should be handled, and also indications for open or closed reductions. These chapters alone are of value to all who come in contact with fractures as a guide or handbook of treatment.

The authors should be congratulated in that they do not present a one-sided picture of a subject in which they have been extremely active and, more or less, pioneers. They take a fair and broadminded viewpoint on the subject, presenting the pitfalls and contraindications, as well as advantages of and indications for internal fixation. They point out on several occasions that internal fixation does not do away with external splinting and warn against overuse of the procedure.

The well organized manner in which the material is arranged and the interesting manner in which it is presented make the book extremely easy to read. There are also excellent bibliographies. Altogether the book should prove useful as an ideal source of reference for every surgeon.

A. B. Rohrbaugh, Jr., M.D.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

Gifford's Textbook of Ophthalmology, 4th ed. Francis H. Adler, M.D., Professor of Ophthalmology, University of Pennsylvania Medical School. Price, $6.00. Pp. 512, with 310 illustrations. Philadelphia: Saunders, 1947.

Pharmacology, Therapeutics and Prescription Writing for Students and Practitioners, 5th ed. Walter Arthur Bastedo, Ph.G., Ph.M. (Hon.), M.D., Sc.D. (Hon.), F.A.C.P., Consulting Physician, St. Luke's Hospital, New York, St. Vincent's Hospital, Staten Island, and the Staten Island Hospital; President, U. S. Pharmacopoeial Convention 1930–1940; member of Revision Committee, U. S. Pharmacopoeia; formerly Curator of the New York Botanical Garden; Attending Physician, City Hospital, New York; Instructor in Pharmacology, Cornell University; Associate in Pharmacology and Therapeutics and Assistant Clinical Professor of Medicine, Columbia University. Price, $8.50. Pp. 840, with 82 illustrations. Philadelphia: Saunders, 1947.

Rypins' Medical Licensure Examinations, 6th ed., under the editorial direction of Walter L. Bierring, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.), former member of National Board of Medical Examiners, American Board of Internal Medicine, and Iowa State Board of Medical Examiners; Professor Emeritus, Theory and Practice of Medicine, College of Medicine, State University of Iowa; Secretary, Federation of State Medical Boards of the United States, with the collaboration of a review panel. Price, $6.00. Pp. 690. Philadelphia: Lippincott, 1947.

Hospital Care in the United States. Commission on Hospital Care. Price, $4.50. Pp. 631. New York· Commonwealth Fund, 1947.

The American Illustrated Medical Dictionary, 21st ed. W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lt. Colonel, M.R.C., U. S. Army; member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association; Editor of "American Pocket Medical Dictionary," with the collaboration of E. C. L. Miller, M.D., Medical College of Virginia. Price, $8.00; with thumb index, $8.50. Pp. 1660, with 880 illustrations. Philadelphia: Saunders, 1947.

Surgery of the Ambulatory Patient, 2nd ed. L Kraeer Ferguson, A.B., M.D., F.A.C.S., Professor of Surgery, Graduate School of the University of Pennsylvania; Professor of Surgery, Woman's Medical College of Pennsylvania; Surgeon, Graduate Hospital of the University of Pennsylvania, Women's Medical College Hospital, Philadelphia General Hospital and Doctors Hospital; Consulting Surgeon, U. S. Naval Hospital; formerly Chief of the Surgical Outpatient Department, Hospital of the University of Pennsylvania; formerly Chief of the Proctologic Clinic, Hospital of the University of Pennsylvania and Philadelphia General Hospital, with Section on Fractures by Louis Kaplan, A.B., M.D., F.A.C.S., Associate in Surgery, University of Pennsylvania; Chief of Surgical Service II, Mt. Sinai Hospital; in charge of the Fracture Division of the Surgical Outpatient Department, Hospital of the University of Pennsylvania. Price, $10.00. Pp. 932, with 645 illustrations. Philadelphia: Lippincott, 1947.

Medical Care and Costs in Relation to Family Income—A Statistical Source Book (Bureau Memorandum No. 51, 2nd ed.) selected and compiled by Helen Hollingsworth, Margaret C. Klem, and Anna Mae Baney, Federal Security Agency, Social Security Administration, Bureau of Research and Statistics. Price, $1.25. Pp. 349. Washington, D. C.: U. S. Government Printing Office, 1947.

Calcific Disease of the Aortic Valve. Howard T. Karsner, M.D., and Simon Koletsky, M.D., Institute of Pathology, Western Reserve University and the University Hospitals of Cleveland. Price, $5.00. Pp. 111. Philadelphia: Lippincott, 1947.

Internal Medicine in General Practice, 2nd ed. Robert Pratt McCombs, B.S., M.D., F.A.C.P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. Price, $8.00. Pp. 741, with 122 illustrations. Philadelphia: Saunders, 1947.

Handbook of Psychiatry. Winfred Overholser, A.B., M.D., Sc.D., Superintendent, Saint Elizabeths Hospital; Professor of Psychiatry, George Washington University, Washington, D. C., and Winifred V. Richmond, B.S., A.M., Ph.D., Late Chief, Department of Psychology, Saint Elizabeths Hospital; Late Consultant in Psychology, New Mexico State Department of Welfare. Price, $4.00. Pp. 252. Philadelphia: Lippincott, 1947.

Endogeneous Endocrinotherapy including The Causal Cure of Cancer Compendium. Dr. Jules Samuels, Specialist for Endogeneous Endocrinotherapy, Amsterdam. Pp. 539. Netherlands: Holdert & Co., Ltd., 1947.

A Textbook of Clinical Neurology with an Introduction to the History of Neurology, 6th ed. Israel S. Wechsler, M.D., Clinical Professor of Neurology, Columbia University, New York; Neurologist, The Mount Sinai Hospital; Consulting Neurologist, Montefiore Hospital and Rockland State Hospital, New York. Price, $8.50. Pp. 829, with 162 illustrations. Philadelphia: Saunders, 1947.

Ear, Nose and Throat: Symtoms—Diagnosis—Treatment. George D. Wolf, M.D., Assistant Clinical Professor of Otolaryngology, New York Medical College. Price, $10.00. Pp. 523, with 149 illustrations, including 25 with color. Philadelphia: Lippincott, 1947.

REPRINTS RECEIVED

The following reprints have recently been received, for which due acknowledgment is made:

"Human Fibrin Foam with Thrombin as a Hemostatic Agent in General Surgery." Orville T. Bailey, Franc D. Ingraham, Orvar Swenson, John J. Lowrey, and Edgar A. Bering, Jr. Surgery, September 1945.

"Report of a Patient Tolerating Crystalline Penicillin without Reaction after Repeated Cutaneous Reactions to Crude Penicillin." Sherwood W. Barefoot and Sidney Olansky. North Carolina Medical Journal, February 1947.

"Observations on the Cause and Transmission of Granuloma Inguinale." Donald C. A. Butts and Sidney Olansky. Archives of Dermatology and Syphilology, November 1946.

"The Treatment of Gonorrhea with Streptomycin." Ben D. Chinn, Lawrence E. Putnam, S. Ross Taggart, and Robert P. Herwick. American Journal of Syphilis, Gonorrhea, and Venereal Diseases, May 1947.

"Institutional Treatment of Juvenile Delinquents." Leonard M. Dub. The American Journal of Psychiatry, May 1947.

"The Connecticut Cancer Record Registry—How It Functions." Matthew H. Griswold and Eleanor J. Macdonald. The Connecticut State Medical Journal, May 1947.

"Most Probable Numbers for Evaluation of Coli Aerogenes Tests by Fermentation Tube Method." J. K. Hoskins. Public Health Reports, Reprint No. 1621.

"Rickettsialpox—A Newly Recognized Rickettsial Disease. V. Recovery of *Rickettsia Akari* from a House Mouse (*Mus musculus*)." Robert J. Huebner, William L. Jellison, and Charles Armstrong. Public Health Reports, May 30, 1947.

"Craniopharyngiomas in Children." Franc D. Ingraham and H. William Scott, Jr. The Journal of Pediatrics, July 1946.

"Experimental Hydrocephalus." Franc D. Ingraham, Eben Alexander, Jr., and Donald D. Matson. Journal of Neurosurgery, 1947, **4**, 164.

"A Simple Method of Making Photographic Records under Sterile Conditions." Franc D. Ingraham and Cully A. Cobb, Jr. Journal of Neurosurgery, 1947, **4**, 293.

"The Meaning of Adjusted Rates for Cancer." Eleanor J. Macdonald. Connecticut Health Bulletin, December 1946.

"Expanded Chronic Disease Program Needed." Eleanor J. Macdonald. Connecticut Health Bulletin, August 1946.

"Rapid Treatment of Prenatal Syphilis." Sidney Olansky and Robert Beck. American Journal of Syphilis, Gonorrhea, and Venereal Diseases, January 1947.

"Fixation of Bones by Plates and Screws." Leonard T. Peterson. The Journal of Bone and Joint Surgery, April 1947.

"Studies of Sewage Purification. XVII. The Utilization of Organic Substrates by Activated Sludge." O. R. Placak and C. C. Ruchhoft. Public Health Reports, May 16, 1947.

"A New *Salmonella* Type Isolated from Man: *Salmonella Texas*." James Watt, Thelma M. DeCapito, and Alice B. Moran. Public Health Reports, May 30, 1947.

"Dr. Prosper Ménière—A Historical Sketch." Walter A. Wells. Laryngoscope, April 1947.

LEON A. MARTEL, M.D., F.A.C.S.

(1883–1947)

Dr. Leon A. Martel, well known surgeon and gynecologist, died unexpectedly at his home, 2812 Bellevue Terrace, N W., October 11. He was Professor Emeritus of Gynecology of Georgetown University School of Medicine, having been a member of the teaching staff for 17 years. His offices were in the Washington Medical Building at 1801 Eye Street, N.W.

Leon A. Martel, M.D.

Dr. Martel was born in Boston, Mass., June 29, 1883. He graduated in medicine from Georgetown University School of Medicine in 1908, following which he interned at Georgetown Hospital and Boston City Hospital. He was resident physician at Columbia Hospital for Women from 1909 to 1910.

In 1912 he began active practice of medicine in the District of Columbia, which practice was interrupted by World War I, when he served as Captain in the Army Medical Corps. He became Associate Professor of Gynecology at Georgetown University School of Medicine in 1924 and later Professor of Clinical Gynecology; from 1930 to 1947 he was Professor and Head of the Department of Gynecology of Georgetown University and Head of the Georgetown Division of Gynecology at Gallinger Municipal Hospital. He was also Chief Attending Gynecologist of Georgetown Hospital and Consulting Gynecologist of Gallinger Municipal Hospital.

Dr. Martel was elected an Active member of the Medical Society of the District of Columbia in 1913. He was a diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American Medical Association and the American College of Surgeons, and a member and Past President of both the Georgetown Clinical Society and the Washington Gynecological Society.

An outstanding athlete, Dr. Martel played fullback on the Georgetown football team while a student in 1904 and 1905. He also was a catcher on the baseball team in those years. He played professional baseball in 1909 and 1910, with the Tri-State and Eastern Leagues and with the Philadelphia and Boston Clubs of the National League. Recently he received an honorable mention as a member of the All-Georgetown All-Time Football Team for a backfield position.

Dr. Martel is survived by his wife, Mrs. Elsie Smith Martel, and a son, Dr. Leon A. Martel, Jr. Two sisters also survive, Mrs. George Dennison and Miss Evangeline Martel, both of Boston.

Gas Shadows in Compound Wounds—McDonald

(*Continued from page 598*)

BIBLIOGRAPHY

1. Laboratory Guide in Bacteriology. Naval Medical School, National Naval Medical Center, 1943.
2. Zeissler, J., and Neller, K.: Anaerobe Wundinfektionen. Arch. f. klin. Chir., 1928, **149**, 793.
3. Mac Lennan, J. D.: Anaerobic infections of war wounds in Middle East. Lancet, 1943 **2**, 63, 94, 123.
4. Altemeier, W. A., and Furste, W. L.: Gas gangrene. Internat. Abstr. Surg., 1947, **84**, 507.
5. Conway, H.: Anaerobic infection and gangrene of war wounds in casualties from Philippine Islands. Surgery, 1946, **19**, 553.
6. Rhinehart, D. A.: Gas and air in tissues; roentgenological study. South. M. J., 1931, **24**, 569.
7. Caldwell, G. A., and Cox, F. J.: Roentgen ray treatment of gas gangrene; clinical and experimental observations. Ann. Surg., 1941, **114**, 263.

Liver Function Tests—Thomas

(*Continued from page 604*)

pointed out. Some of the newer liver function tests have been discussed, outlining their technic, advantages, disadvantages and fields of clinical application. A possible relationship between liver dysfunction with associated abnormal protein metabolism and the mechanism of some of these tests is reviewed. It is suggested that evaluation of liver function can be best obtained by the use of a series or battery of sensitive and reliable tests, each of which is based upon a different activity of the liver.

BIBLIOGRAPHY

1. Mann, F. C.: Discussion of paper by Mateer et al (see ref. 8).
2. Bollman, J. L., and Mann, F. C.: Ann. Int. Med., 1931, **5**, 699.
3. Hoffbauer, F. W., Evans, G. T., and Watson, C. J.: M. Clin. North America, 1945, **29**, 363.
4. Hanger, F. M.: Tr. A. Am. Physicians, 1938, **53**, 148.
5. Hanger, F. M.: J. Clin. Investigation, 1939, **18**, 261.
6. Pohle, F. J., and Stewart, J. K.: Ibid., 1941, **20**, 241.
7. Rosenberg, D. H., and Soskin, S.: Am. J. Digest. Dis., 1941, **8**, 421.
8. Mateer, J. G., Baltz, J. I., Marion, D. F., and Hollands, R. A.: Ibid., 1942, **9**, 13.
9. Thomas, L. J.: Unpublished data.
10. Wade, L. J., and Richman, E. E.: J. Lab. & Clin. Med., 1945, **30**, 6.
11. Neefe, J. R., and Reinhold, J. G.: Science, 1944, **100**, 83.
12. Moses, C.: J. Lab. & Clin. Med., 1945, **30**, 267.
13. Gray, S. J.: Arch. Int. Med., 1940, **65**, 523.
14. Maclagan, N. F.: Nature, London, 1944, **154**, 670.
15. Kabat, E. A., Hanger, F. M., Moore, D. H., and Landow, H.: J. Clin. Investigation, 1943, **22**, 563.
16. Rosenthal, S. M., and White, E. C.: J. Pharmacol. & Exper. Therap., 1924, **23**, 265.
17. Mac Donald, D.: Surg., Gynec. & Obst., 1939, **69**, 70.
18. Israel, H. L., and Reinhold, J. G.: J. Lab. & Clin. Med., 1938, **23**, 588.
19. Mateer, J. G., Baltz, J. I., Marion, D. F., and Mac Millan, J. M.: J. A. M. A., 1943, **121**, 723.
20. Quick, A. J., Ottenstein, H. N., and Weltchek, H.: Proc. Soc. Exper. Biol. & Med., 1938, **38**, 77.
21. Lord, J. W., Jr., and Andrus, W. DeW.: Arch. Int. Med., 1941, **68**, 199.
22. Warner, E. D., Brinkhous, K. M., and Smith, H. P.: Am. J. Physiol., 1936, **144**, 667.
23. Ivy, A. C., and Roth, J. A.: Gastroenterology, 1943, **1**, 655.

Unnecessary Surgery—Horwitz

(*Continued from page 608*)

supervene. Herniae, adhesions, and intestinal obstruction are only a few of the possible later complications. These dangers are accepted when an operation is found to be definitely indicated, but how can we condone these in the face of uncalled-for operations?

Knowing the causes of unnecessary surgery the remedy should be obvious. To avoid such surgery we must improve our diagnostic acumen, improve our knowledge of physiology and pathology, and be extremely careful in our evaluation of symptoms as they apply to the particular patient under our care. Let every surgeon feel that upon him rests a grave responsibility. He is both judge and jury and should beware of being also the executioner. The surgeon might well take for his motto the quotation used by a well-know drug firm, and let the priceless ingredient of his product be integrity and honor. The greater surgeon is he who knows when not to operate. And always there is the Golden Rule to follow: Do not unto others that which you would not have done unto yourself.

900—17th Street, N.W.

Extragenital Chancre—Robinson

(*Continued from page 611*)

"kissing chancres" on the lips of patient number 1 but she persistently refused. Later she permitted photographs of the scars. It is extremely regrettable that photographs of these unusual lesions are not available. That syphilis can be transmitted by osculation and intermediate objects with ease has been demonstrated. This mode of transmission must be kept constantly in mind. Whether the osculation is performed in venery or merely as a token of esteem is not of scientific interest. The failure of the mother to transmit the disease to her 2 children while she was in an extremely infectious state is difficult to explain, although she admitted that both she and her "husband" frequently kissed the children. Why some people exposed to infectious syphilis acquire the disease whereas others exposed to the same source do not, makes the problem of the transmission of syphilis mysterious and puzzling.

Hawley Speaks His Mind—Observer

(*Continued from page 629*)

changes, and perhaps radical ones. If they are extreme, they will not be confined to medicine alone. Our whole social fabric will be similarly affected.

All in all, Dr. Hawley, if his remarks are accurately reported, has not done credit to himself or his profession. T. W.

Washington Physicians of Yesterday—Belt

(*Continued from page 636*)

Dr. Belt was a man of high principles, pleasing personality, a Christian gentleman; possessing eminent scientific attainments, he was a contributor to medical literature, and originator of sponge-grafting in the orbit to prevent a sunken appearance after removal of the eye.

He married Emily Walker Norvell May 18, 1899, and by her had three sons.

At 6:30 p.m. on Sunday, December 30, 1906, at Terra Cotta, Maryland, a short distance outside of the District line, occurred the worst railroad disaster that has ever happened in the Washington area. About fifty persons lost their lives in the wreck, and as many more were injured, plunging the city into profound and widespread horror and grief. Among those that were instantly killed were Dr. Belt and two of his young sons. By a trick of fate, the other two members of the family escaped the disaster, a four-year-old son who was confined to his home by a lucky (!) fracture of his thigh, and Mrs. Belt, who was caring for the latter. The surviving son, now mature and creditably carrying on the medical talent innate in the Belt family, is Dr. Norvell Belt, well known urologist of this city.

John B. Nichols, M.D.

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MEDICAL STATESMANSHIP*

EDWARD L. BORTZ, M.D., F.A.C.P.
President, American Medical Association

Introduction

LEADERSHIP in human relationships concerned with health and the control of disease should come from the medical profession. By training and experience, and by intimate and sympathetic contact with their fellow men, physicians are close to human problems—the hopes and fears, the traumas and diseases which daily bring so much unhappiness and so much destruction to human life. Because of these qualifications society looks to physicians to direct the search for better methods in the control of disease, and for the building of a more vigorous and healthy population. Society has made a generous investment in training its physicians. The standards are high, the road is long. Yet in the last century the accomplishments of medical science have brought about more effective control of disease, increased the life span, and extended the useful years. This statement needs some qualification because there are large segments of our own population and throughout the world national groups who, for various reasons, have not participated in the magnificent benefits that modern scientific medicine has to offer. The time is appropriate for a consideration of means which may bring these benefits to the less favored segments of human society. Examination of mortality statistics focuses attention on the major disorders which are incapacitating our fellow men and destroying more than one million lives in our own country each year.

What has this to do with medical statesmanship? In the *Pennsylvania Medical Journal* one reads that "medical statesmanship comprises the art of changing health conditions from what they are to what they ought to be." At many medical centers throughout the Nation each year medical organizations are carrying on superb courses of postgraduate instruction for practicing physicians. Recognized teachers are presenting important new data for physicians to carry back home. The practice of medicine is increasingly effective in the treatment of various common infections, nutritional deficiencies, metabolic abnormalities, and many kinds of tumor growths.

Members of the medical profession too often have neglected their obligations as citizens. Their understanding of human relationships fits physicians for participation in the formulation of policies to create a more stable society. In a sick world all of society's resources need to be mobilized for its own protection. Medicine has so much to offer. It aims to produce a wide base of support to each human need. It hopes to establish deep wells of comfort for troubled minds. It aspires to help people meet their daily problems with strong bodies, clear minds, and stout hearts. Physicians must be expert in the art of human relations. A distinguished jurist has recently stated that the medical profession must pursue a policy of vigorous self-assertion in providing the basic essentials of human needs. Adequate health measures are an essential foundation for the efficient functioning of any people as a nation, for the promotion of the general welfare, and for the preservation of their national existence.

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* Address delivered at the Past Presidents' Dinner, October 8, 1947, during the Eighteenth Annual Scientific Assembly of the Society.

Medical men have frequently become distinguished public servants, and have had their names engraved in the Nation's recorded history. Twenty-one members of the First Provincial Congress of Massachusetts were physicians. Three physicians signed the Constitution of the United States, and six signed the Declaration of Independence. According to Browning,[1] 274 physicians served in Congress between 1789 and 1910. Browning, after reviewing the activities of doctors in Congress, does not believe that physicians lose their medical conscience when they enter the realm of politics. He emphasizes that physicians can be of especial service to the community as representatives of a great profession.

As far as I know, Browning's original list has not yet been brought up to date. In the 78th Congress there were seven physicians. In the 79th Congress there were likewise seven. Someone with a flare for medical history might render the profession and the Nation a service by a review of the activities of medical men in public office. Surely a physician should be able to furnish the members of Congress with authoritative information in the various fields of medical science. As Representative Walter H. Judd of Minnesota, a physician, pointed out, one might believe there would be little difficulty in presenting medical evidence clearly to legislators. In practice, apparently, medical information which might be obtained from medical members of Congress is, for the most part, submerged by party loyalty and political expediency. Judd was convinced that what is most to be desired is more physicians in government and, above all, more of the kind with mental habits that good doctors must possess. Judd makes the statement that it is difficult for Congress to obtain information concerning medicine.

There is universal praise concerning the activities of medical men during the War. The high efficiency of the Medical Corps with the low mortality rate from wounds and infection, the control of epidemics, and the proficiency of prophylactic measures have received much praise. When representatives of the medical profession get into the political arena their services are not so widely utilized. Nevertheless, history records occasional individuals who have played important roles in directing the destinies of their native land. Indeed, in the early history of our Nation the fighting-rebel-parsons frequently were physicians; two were Green of Hanover and Darby of Parsippany.

In a splendid article Eagleton[2] describes the deteriorating influences of the Industrial Revolution which came upon the national scene in the middle of the last century; then, politics as a major interest ceased to attract the attention of medical men.

As medical science has broadened its field of knowledge and the medical career has become more exacting and time-consuming, physicians have for the most part forsaken the field of civic interests and apportioned their time almost entirely to medical service. The capacity and ability to participate in community activities and affairs of the state has been demonstrated by a number of brilliant examples. Dr. Charles Robinson was the first Governor of Kansas, John Winthrop, Jr. was the Governor of Connecticut, William Wyatt Bibb of Alabama, Josiah Clayton of Delaware, and Edward Tiffin of Ohio.[3] It is pointed out by Edwards[4] that Dr. Thomas Wynne, who accompanied William Penn on his first visit to America, was chosen President of the First Provincial Assembly of Pennsylvania. In

1628 Dr. John Pot was Deputy Governor of the Colony of Virginia.

John Evans, born in 1814, was a physician, founder of universities, and railroad builder.[5] He attained prominence in three states, Indiana, Illinois and Colorado. Dr. Evans was Professor of Obstetrics at Rush Medical College in Chicago, and also was one of the editors and proprietors of the *Northwestern Medical and Surgical Journal.* He was an alderman in the city in 1853 and 1854, and was selected as Chairman of the Committee on Schools. He took a leading part with Orrington Lunt in the foundation of Northwestern University. It is interesting to note that Evanston, Illinois, was named after him. He was appointed the territorial Governor of Colorado in 1862. He was a military leader and fought Indians. In 1865 he was elected United States Senator, but because Colorado had not as yet become a state he never sat in Congress. Dr. Evans was the founder of the University of Denver, and the President of its Board of Trustees from its inception until his death.

In more recent years rather frequently outstanding medical men have participated in the public welfare of the Nation. Dr. Hubert Work, at one time President of the American Medical Association, was Secretary of the Interior in the Cabinet of Calvin Coolidge. Dr. Ray Lyman Wilbur, another President of the Association, at one time held the same portfolio in the Presidential Cabinet.

General Leonard Wood, 1860 to 1927, was described by the distinguished British Surgeon Lord Moynihan[6] as "the greatest Colonial Administrator America has yet produced." In 1910 he became Chief of the General Staff. In 1918 he was wounded and returned to Washington; he just missed the presidency of the Nation. Clemenceau "The Tiger," a medical doctor, was recorded by many as the saviour of France. The first President of the Chinese Republic, Sun-Yat-Sen, was a medical man.

EXPERIMENTS IN DEMOCRACY

The ideals on which our Nation was founded were based on freedom and a recognition of the rights of the individual. Government is an instrument in the hands of the people for the creation of a more abundant flowering of the human spirit. Under this principle, laws were enacted which promised a wider distribution of national assets and an encouragement of individual initiative. These tenets were firmly imbedded in the minds and hearts of American pioneers. With modern civilization two opposing theories of government have become dominant. What has this to do with medicine? The problems of the individual are the matrix of the physician's life work. His position in the family of patients and in the community fits him for civic service. He is trained in the scientific method, and has accustomed himself to the capacity for critical analysis and independent thinking. Before the good physician makes a diagnosis he surveys all possibilities. In brief this is the method that has driven science forward and charted unexplored seas. The physician has faith in the intelligence of his patient and the community. He has tolerance, he recognizes the value of democracy, that is to say, the scientific method. A free and open discussion and a pooling of ideas is most likely to result in a solution satisfactory to all. Scientific discussion groups as described by Spencer[7] are small-scale experiments in democracy. There is no evasion of criticism. On the contrary, all points of view are considered. Unfortunately, in the social sciences emotionalism and evangelism have too often replaced scientific detachment and accurate analysis.

The social fabric today, in order to guarantee the future of society, must be examined in the light of reason and absence of heat. Social progress can be furthered by the experimental method which has proved so fruitful in the realm of the physical sciences. There is need for larger loyalties and broader vision to replace the narrow concept of temporary satisfactions.

In a brilliant address recently, H. W. Prentis, Jr.[8] remarked that if our type of free society is to be preserved, professional and businessmen must not only be good technicians but also good citizens in every sense that these words imply. Interest in public affairs is one of the major responsibilities of the American physician even at the cost of less time in the office, clinic or laboratory. Participation in formulating policies for social betterment offers opportunities for accomplishment in serving mankind. In the busy world of today the wear and tear of daily living is producing stresses and strains on many people who seek medical advice. The family physician is the father confessor of people with weary souls and troubled minds, who ofttimes are discouraged with the turn of events from day to day. The double role of the physician today as the family doctor and the father confessor places him in a unique position for social influence. Historically the father of medicine, Hippocrates, was the priest physician; whereas in modern times the dramatic events of the laboratory and the amphitheater draw attention to the material accomplishments, the greater field of medical service falls into the realm of the emotions and ambitions of those whom the doctor serves. One of the contributions of contemporary literature is a small volume entitled "Peace of Mind" by the distinguished Rabbi Liebman[9] of Boston. The title of this book is the simple definition of what all the world is seeking. It deals with the basic fundamentals of enduring human satisfactions. I want to emphasize that the medical profession in its daily duties meets these important human problems. Researches in the mechanism of mental disorders are rapidly bringing light and order into the dark recesses and chaos of disordered minds. In the final analysis man today need have no fear of the atom bomb and other highly destructive material forces. Man's great enemy today is himself.

Life Science

Since the turn of the Century science has substantially increased its knowledge of the human body and the elements which threaten to destroy it. During this same period the world has seen the two bloodiest wars in history. Leading scientists have commented on the biologic and sociologic aspects of conflicts between nations. When he was President of the American Association for the Advancement of Science, Walter B. Cannon stated that, in addition to disease and the heavy forces of poverty, the most universal and persistent enemies of mankind are ignorance and moral degradation. He believed that those who are guilty of starting war between human beings are traitors to all men. At the time when men should be directing their energies in search for improving human relationships they are drawn into the sterile field of mutual destruction.

Can modern science be used to remove some of the major causes of war? President Karl T. Compton of the Massachusetts Institute of Technology believes that science may eliminate certain economic considerations which constitute the major causes of war by synthetically replacing the world's natural resources. When science can manufacture substitutes for petroleum, coal, rubber, and other essential materials, the need for employing armed force to acquire territory rich in these products may at least be diminished. In so far as wars are caused by the natural "cussedness" of man, science by analyzing human nature may focus attention on its antisocial potentialities.

Life science, the term popularized by Sir Thomas Lewis some years ago and more recently used by Oscar Riddle, offers the only possible hope for the stability of society and international relationships. Yet the failure to utilize well known facts contributes greatly to the suffering of humankind. As the span of life is increasing, the quality of its existence and its security become important. Society which fosters research to save human life should not expose the lives thus saved to weapons of destruction. The scientific method has yielded rich rewards in the conquest of disease and other afflictions of the body. When this method becomes applicable to social problems, human society will have new safeguards for its continuity.

NONPARTISANSHIP

A review of the activities of physicians who have entered the political arena indicates that the majority of them appear to have neglected their profession and became active in the arena of partisan politics. To the extent that they failed to utilize their understanding of basic human problems derived from experience as physicians, their value as physicians was diminished. By training and understanding they should have been able to play a dominant role in aiding legislative bodies in their search for social adjustments. If society makes a heavy investment in the medical profession, the profession should rise to its height in its services to the Nation. Medical statesmanship, the participation of physicians in the great art of statecraft, has much to offer. The time is at hand for coöperation on all issues in which there is common agreement. Known facts should be clarified, then immediately utilized in producing a healthier society. The scientific method should be encouraged for the discovery of new and better ways to better health. Social experiments for the improvement of health and the control of disease may be set up locally, under controlled conditions, and supervised by members of the medical profession and representatives from other civic groups, to study the issues on which there is a reasonable difference of opinion. Experiment, observe, reason, then conclude. The elimination of rancor, emotional outbursts and false accusations is essential to the rational study of the problem of medical care for the entire Nation. Then, too, the medical profession—the physicians themselves—should air their differences within the family. They have their own county and state bodies. Organized medicine has followed the democratic method in the selection of its officials. There is ample opportunity for each one to participate in the formulation of medical policies at all levels. Loyalty to the organization which protects the interests of the profession in its search for larger service to the Nation is important to every physician. The closest examination of the motivations of American medicine as crystallized in the activities of the American Medical Association will reveal a constant striving for more effective ways to improve the public health, control disease, extend the span of life, raise the level of medical education, eliminate quacks, and improve the state of health of the entire population.

IMMEDIATE OBJECTIVES

Energetic leadership in American medicine today can play a dominant role in the following manner:

1. Public Education. If health is the Nation's most important asset, then each grade school, secondary school, and college should immediately place instruction on matters of health high on its list of subjects to be taught and give adequate credit for acquisition of such knowledge.

2. More adequate medical care must be extended to all portions of the population. Where deficiencies exist, does it not seem logical that social experiments should be established under the leadership of medicine in the search for ways and means to bring this about? The population of our Nation is heterogeneous. It is made up of many nationalities and groups with every conceivable variety. The needs of one region are not those of the whole. By local experimentation adequate measures for medical service to all persons can be more satisfactorily developed.

3. The promotion of a World Medical Association with the following objectives:

(a) To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available.

(b) To maintain the honor and protect the interests of the medical profession.

(c) To study and report on the professional problems which confront the medical profession in the different countries.

(d) To organize an exchange of information on matters of interest to the medical profession.

(e) To establish relations with, and to present the views of the medical profession to the World Health Organization, UNESCO, and other appropriate bodies.

(f) To assist all peoples of the world to attain the highest possible level of health.

American medicine has recently sent four of its top statesmen to an important conference in Paris. Since medical science knows no boundaries, closer collaboration among physicians throughout the world may foster better understanding among all people.

Last summer one of our Nation's loyal medical statesmen made an extensive trip throughout South American countries to study their medical needs for the purpose of assisting in the creation of a higher level of medical education for our South American brothers.

"The extension of medical and public health projects from the United States to Latin America has served to introduce much of what is best in the medical science of the United States to millions of people who previously had little if any knowledge of the American way in medicine. Such movements as the Confederación Médica Panamericana, the World Medical Association, and the World Health Organization offer opportunity never previously available for emphasizing the international character of medical science and its leadership in promoting world peace."[10]

4. At a time when a ruthless dictatorship is aggressively extending its power over weaker and vulnerable nations our medical profession must be alerted to its responsibility in the event of international conflict. We have not seen our last war. The psychologic phase of the next conflict is already upon us. There is enlightened leadership in the medical corps of the armed forces. In the atomic era a coördinated medical program is absolutely essential for the security of the Nation. Energetic leadership for the profession is necessary. Medical statesmanship is essential for presenting an adequate program to the members of Congress and the military leaders. Today organized medicine can render a great service to the national security by the support of the augmented medical program which is now becoming a reality for the armed forces. In the next conflict all areas of the Nation may be vulnerable. Accordingly, a Nation-wide emergency medical plan is indicated.

5. Medical research. The acquisition of additional medical knowledge through research is vitally necessary. Its application through medical statesmanship should be directed toward social progress. Support of research by Government and private agencies should reveal helpful information in the control of the major disorders which today represent the captain of the men of death. The degenerative lesions of the body, cancer, tuberculosis, diabetes, rheumatism and the others, will eventually yield to the never-ceasing search of medical investigators. If these are brought under control, unless there is a closer understanding of human relationships at the individual and also at the national and international levels, mankind will have gained an empty victory. Society needs to mobilize its forces today for the control of antisocial and unhealthy human trends which have brought two world catastrophes within the past quarter century. The enduring satisfactions of human existence may be attained for mankind when the scientific methods which have brought such spectacular results in the control of somatic diseases have been extended into the sphere of human relationships. Therein lies the hope for the human race.

No other group is more eminently qualified by interest, training, and experience to direct the work of social stabilization than the medical profession. Individual human beings and their reactions, singly and in groups, constitute the physician's principal concern. Medicine should play a leading part in directing the destinies of the social order. "A consolidated medical opinion might speak with a voice to which governments would listen."[10]

(*Continued on page 718*)

VARICOSE VEINS AND THE VARICOSE STATE*

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PHYSICIANS see many patients for varied diseases who have coëxistent, symptomless varicose veins. Only a small percentage of the patients who have varicose veins seek treatment for them. In fact, the great majority of patients seek treatment for the late manifestations of varicose veins and the complications associated with this disorder, not for the primary pathology.

The first and most important question in the mind of every doctor who examines a case of varicose veins should be: "What can I do for this patient which will give the most permanent and effective result in the shortest space of time, and with the least danger and discomfort to the patient?" In other words, "Shall I disregard the varicose veins, inject them, or advise the patient to be operated upon and receive subsequent injections?"

This paper is a review of the anatomy, the physiology and the symptoms of varicose veins, a presentation of the tests to be performed for an accurate diagnosis, and finally to present a detailed plan of treatment for the patient.

ANATOMY

The two major superficial veins of the lower extremity are the internal saphenous vein (greater), which empties into the femoral vein, and the external saphenous vein (lesser), which enters chiefly into the popliteal. One other rather large branch enters into the beginning of the profunda femoris. The tributaries of the internal saphenous vein are the lateral superficial femoral, the medial superficial femoral, the external pudendal, the superficial epigastric, and the external circumflex iliac. There is also a group of superficial veins which empty into the internal iliac veins through the pelvis; they drain only partially the superficial part of the posterior thigh, the subgluteal area, and the inner aspect of the thigh. The deep veins of the lower extremity are the anterior and posterior tibial, the popliteal, and the femoral. Communicating veins connect the internal saphenous vein and the deep veins of the leg. Many texts describe numerous communicating branches. However, Ochsner and Mahorner[1] describe the internal saphenous and its communicating branches as follows: "If one inspects closely the normal internal saphenous vein in the adult after it has been opened longitudinally, it is surprising to find that except for several rather large openings on each side of the wall of the vein which can be demonstrated to be the openings of the large superficial tributaries of the internal saphenous vein, there are no ostia of any appreciable size. About seven openings of a size large enough to be identified grossly can be seen from inspection of the inner wall of the saphenous vein on the thigh. Most of these are the openings of large superficial tributaries. There are a few extremely minute orifices on the posterior wall. These are the openings of the communicating veins and they are surprisingly small" (fig. 1).

PHYSIOLOGY

For all practical purposes we may consider the internal and external saphenous veins as the chief veins of varicose changes. However, the superficial group which enter into the iliac veins should be borne in mind, since varicosities of this group may be present and usually require specific therapy.

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In the normal circulation the major portion of the blood from the lower extremity is returned by the deep veins, and the remaining portion by the superficial. This is accomplished in the deep circulation chiefly by the pressure from below and by the pumping action of the contracting skeletal muscles. In the superficial circulation the venous return is accomplished by the same two forces plus the lifting action of venous valves. Therefore, the blood flows upward through the deep and superficial circulation, and, if there is any shunting of blood between the two, it is from the superficial through the communicating to the deep.

When varicosities are present, the venous circulation is altered, and the valves in the saphenous vein fail. One of the most frequent valves to fail early in the process is the saphenofemoral. As the valves become incompetent, the pressure in the vein increases, first in localized areas, and then throughout the entire chain. The valves in the communicating branches also fail, in part or altogether, and blood will then be shunted through these branches from the deep circulation to aggravate the stagnation and thus increase the pressure in the superficial circulation. The normal pressure of the superficial circulation is from 10 to 20 cm. of water in the upright position, and in the varicose state it may rise to a 100 or 150 cm. of water or more. In this latter condition there is a definite increase in the concentration of metabolic substances, and a decrease in the oxygen content of the blood. The tissues quickly reflect this condition. There is also a forced pressure upon the capillary system and venules which causes edema. The color of the extremity about the ankle frequently changes because of the diapedesis of red blood cells and the resultant deposit of the hemoglobin pigment in the subcutaneous layer. We believe that this stagnant superficial circulation in which the blood flows toward the periphery, or flows very slowly from the periphery to the heart, is probably the chief cause of discomfort and of the complications which occur in varicose veins. To this stagnant circulation and its complications, whether it be diffuse or localized, the term "varicose state" is applied. The question which arises next is: Why do some patients with large and prominent veins of the leg not complain of

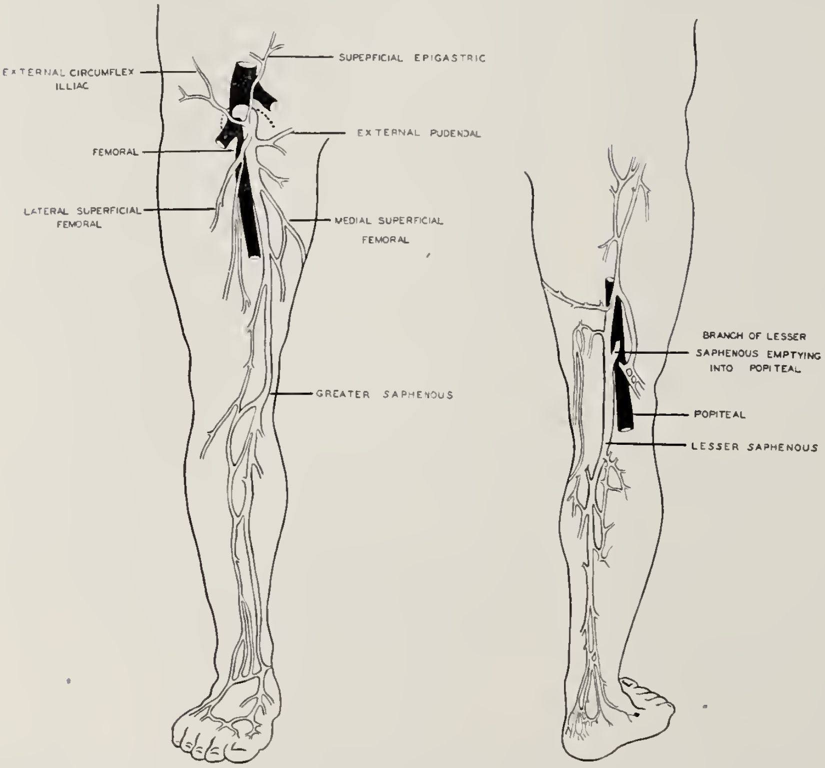

EXTERNAL CIRCUMFLEX ILLIAC
SUPERFICIAL EPIGASTRIC
FEMORAL
EXTERNAL PUDENDAL
LATERAL SUPERFICIAL FEMORAL
MEDIAL SUPERFICIAL FEMORAL
GREATER SAPHENOUS
BRANCH OF LESSER SAPHENOUS EMPTYING INTO POPITEAL
POPITEAL
LESSER SAPHENOUS

Fig. 1. The more important venous channels in which varicose change may occur.

any pain, nor exhibit any discoloration or edema after being up and about all day; and why, conversely, do patients with perhaps only a localized varicose vein or no visible varicosities develop all the complaints and the complications, such as pigmentation, thickening of the skin, and finally ulceration? We feel that the probable explanation is the presence of the varicose state (stagnant circulation) at a localized varicosity, at a localized incompetency in the communicating branches, or in an entire incompetent group of vessels (fig. 2). It is our impression that occasionally this localized stagnation of blood flow may be due to localized thrombophlebitis with its associated venous obstruction. Another explanation for the localized changes may be the presence of deep venous obstruction in the popliteal or tibial vein.

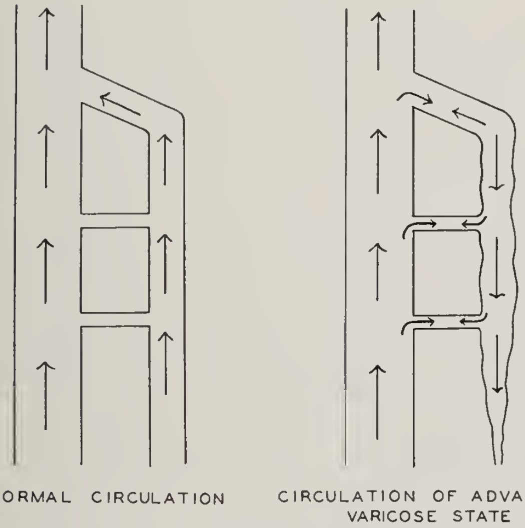


Fig. 2. The mechanism which produces the varicose state.

Any diagnosis of varicose veins and the varicose state with its redundant circulation is divided into three steps:

1. General history and physical examination.
2. Specific history relating to the state of the veins and arteries of the extremity.
3. Specific examination of the extremities with the performance of such tests and their interpretation as is necessary to obtain a complete picture of the pathology and the pathologic physiology which exist within the venous system.

The History

The general history and physical examination should be thorough and complete, since there may be other conditions present which may very well demand therapeutic precedence over the varicose veins. Examples include active tuberculosis, myocardial disease, blood dyscrasias and malignant neoplasms. One may also, by this history and physical examination, find the cause of the varicosities, such as the presence of a pelvic tumor or a fetus.

The specific history should indicate questions which will discover the following states:

A. Anatomic deformities, bone spurs, pes planus, genu valgum, sacroiliac or lumbosacral disease, and true sciatica. We have found that flat foot is present in approximately 50 per cent of the cases revealing varicose veins and is often an important complaint and a contributing factor to the physical discomfort of the patient. Levin[2] has found flat foot in 58 per cent of his cases of varicose veins in a study of 300 patients.

B. Traumatic infections or neoplastic diseases.

C. Inadequate arterial circulation.

D. Lack of patency in the deep venous system.

E. The presence of inflammation or infection of the deep or superficial venous system.

Some of the standard questions which are used and the systems and pathologic states to which these questions refer are indicated below:

1. Do your feet get cold readily? (Arterial disease)
2. Do your feet turn red when they hang down for any length of time? (Arterial or venous obstruction)
3. Do your feet become unusually pale when elevated? (Arterial impairment)
4. Do you have cramps in your legs when walking, and how far can you walk without any difficulty? (Arterial disease)

5. Do you wake at night because of a sharp, cramping pain which is relieved by rubbing or moving the leg about? (Arterial and venous impairment)

6. Have you ever had "milk leg"? (Deep venous system thrombophlebitis) The symptoms and manifestations of this condition should be described to the patient.

7. Do your feet swell? When? How much? Are they completely relieved by rest and elevation? (Superficial or deep venous obstruction)

8. Have you ever had redness and pain in the veins of the skin with swelling which required you to seek treatment? (Superficial system thrombophlebitis)

The symptoms most often experienced in cases of progressive venous insufficiency in the order of decreasing frequency are:

1. Tired, heavy sensations in the leg.
2. Cramping of the calves at night or in cold weather.
3. Swelling of the ankle or dorsum of the foot.
4. Pain radiating along the course of the saphenous vein.
5. The presence of varicosities.
6. The presence of itching and a skin ra h.
7. The presence of an ulcer.
8. A hot, reddened, swollen extremity.

The Physical Examination

The specific physical examination of an extremity is best carried out in the manner subsequently to be described, and should yield the following information:

A. The efficiency of the arterial circulation.

B. The efficiency of the deep venous circulation.

C. The efficiency and competency of the valves and the superficial circulation.

D. The efficiency and competency of the communicating veins.

The efficiency of the arterial circulation is determined by a lack of rubor on dependency or the presence of severe pallor on elevation. A normal pulsation of the dorsalis pedis and posterior tibial arteries and no history of arterial insufficiency such as cramps on walking or severe rest pain are factors to be considered. If there is any question at this point whether or not the arterial circulation is adequate, an oscillimetric reading should be determined.

The efficiency of the deep venous circulation is best determined by the Perthes' test, by the compression test, and by the comparative tourniquet test of Mahorner and Ochsner.

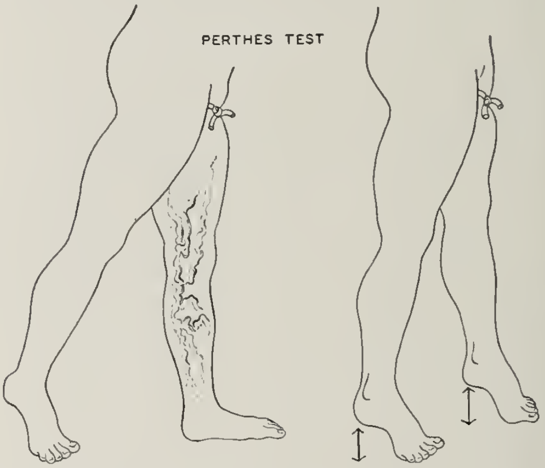


FIG. 3. Tourniquet in proper position to prevent backflow through the greater saphenous vein in Perthes' test.

The Perthes' test is executed thus: The patient stands and a tourniquet is applied to the thigh at a level just below the saphenofemoral junction and firmly enough to compress the internal saphenous vein and to prevent the flow of blood through the saphenofemoral junction. The patient is then instructed to walk briskly or to rise up and down on his toes about 30 times. If the deep channels are patent, the entire internal saphenous vein collapses and the patient experiences no discomfort. This is one of the most important tests to be performed before the treatment of any patient with varicose veins. The test also shows, if negative, that the communicating branches are patent. If positive, the superficial veins do not collapse and the patient experiences discomfort (fig. 3).

The compression test is executed thus: An elastic cotton bandage is placed upon the leg when the veins are emptied, from the foot up to the tibial tubercle, utilizing enough tension to keep the superficial veins collapsed. The patient then walks for approximately 30 minutes, and if at the end of this time he does not experience any cramps of discomfort, the deep circulation is assumed to be adequate. If, however, the patient complains that he cannot tolerate the bandage on his leg, the deep circulation is assumed to be inadequate; in other words, the patient requires his superficial circulation to guarantee efficient return of the blood from the lower extremity. In occasional cases this test is not clearly definitive, and the patient should be advised to wear an elastic stocking continuously for a week. During this time, if the patient finds that there is no more discomfort and that he tolerates the stocking very well, the deep circulation and the communicating circulation are efficient. If, however, the patient comes back and says, "I cannot stand this on my leg," the deep circulation is inadequate. This test is the one frequently used for elderly patients in whom there is some suggestion of arterial impairment and the history or physical findings are suggestive of a previous "milk leg."

The comparative tourniquet test of Mahorner and Ochsner[1] is executed thus: The patient walks to and fro in front of the examiner while his lower extremities are observed. Thereafter, a tourniquet is applied high in the upper third of the thigh, tightly enough to obstruct flow in the superficial venous system at that level. The patient then walks again, while the rate and degree of collapse of the internal saphenous vein is noted. The tourniquet is then removed and reapplied to the middle third, and again in the lower third of the thigh, as the observations are repeated (fig. 4). In certain instances a tourniquet may also be applied below the knee. If the varicose veins become less prominent, but do not completely disappear when a tourniquet is applied to the upper third of the thigh but disappear entirely when the tourniquet is at the lower third, the test indicates that there is retrograde flow from the deep to the superficial system through communicating veins which have incompetent valves below the highest level in the thigh. Therefore, this test not only discloses the condition of the deep veins but also competency or incompetency of the communicating veins. If they are incompetent, the exact levels of such valves are also determined.

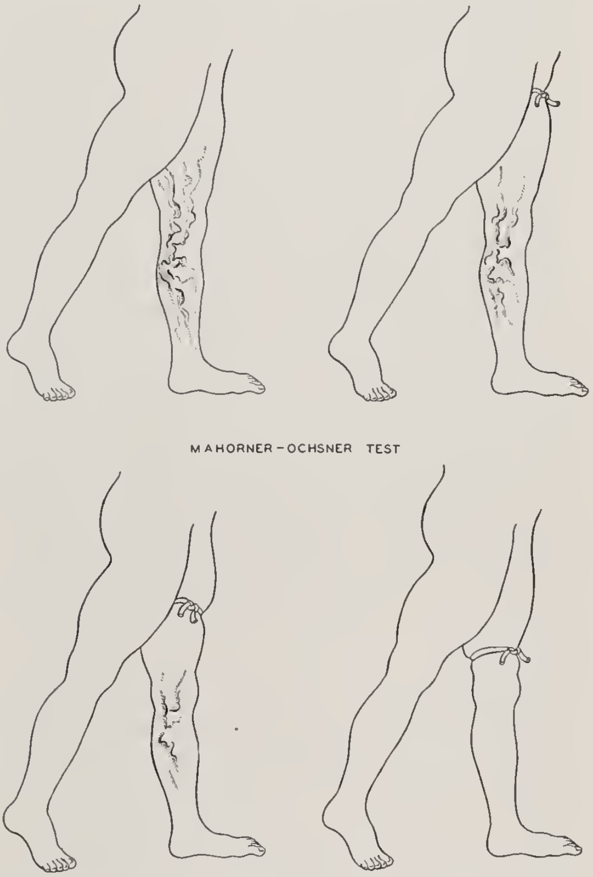


Fig. 4. This test, described in the text, is a valuable one when properly performed.

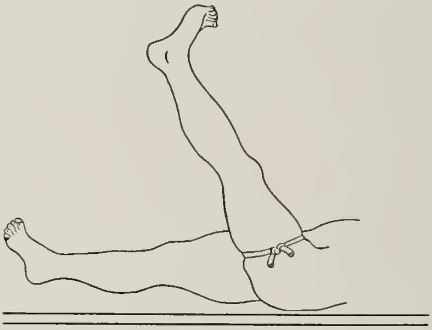
The efficiency and competency of the saphenofemoral valve and the internal saphenous vein is accomplished chiefly by the Trendelenburg, the double positive Trendelenburg, and the cough test.

The Trendelenburg test is executed by having the patient lie down with the leg elevated and the veins emptied. The patient then stands, and it is noted whether or not the veins fill quickly or slowly from below up or from above down. If the vein fills quickly from above downward, it is interpreted as representing an incompetent saphenofemoral valve. The patient then reclines again, the veins are emptied, and a tourniquet is applied to the thigh just below the saphenofemoral junction firmly enough to compress the superficial circulation. The patient stands, and the tourniquet is quickly released; the degree and rate of filling of the veins, chiefly from above downward, indicates the degree of incompetency of the saphenofemoral valve and of the valves in the internal saphenous chain. This is called a positive Trendelenburg test. A modification of this test, the double positive Trendelenburg, requires having the patient stand after emptying the veins, with the tourniquet applied and left on. If the veins fill within 35 seconds, the test indicates that the blood is being shunted partially through the communicating veins from the deep. A normal internal saphenous vein requires 35 seconds or more for complete filling. Therefore, if the veins do not fill within 35 seconds by this test, one may interpret this as representing normal communicating veins and that the superficial system is being filled by the blood flowing through the capillaries (fig. 5).

The cough test is executed by placing the tips of the fingers on the internal saphenous vein at any point from the groin to below the inner border of the knee and asking the patient to cough. An impulse varying in strength up to a clear thrill may be discovered; it indicates incompetence of the valve at the junction of the internal saphenous and deep femoral vein.

The efficiency and competency of the communicating veins is evaluated by the double Trendelenburg, the Perthes', and the Mahorner-Ochsner tests. These have been discussed above, and therefore will not be repeated here.

The efficiency and competency of the external saphenous vein is determined when a tourniquet is placed just above the knee and another tourniquet is applied just below the knee; both the Trendelenburg and the Perthes' tests are performed and evaluated in the same manner as they would be for the internal saphenous vein. Performance of the Trendelenburg and Perthes' tests will in most cases give the necessary information for an intelligent evaluation of the deep and superficial venous systems.



BRODIE-TRENDELENBURG TEST

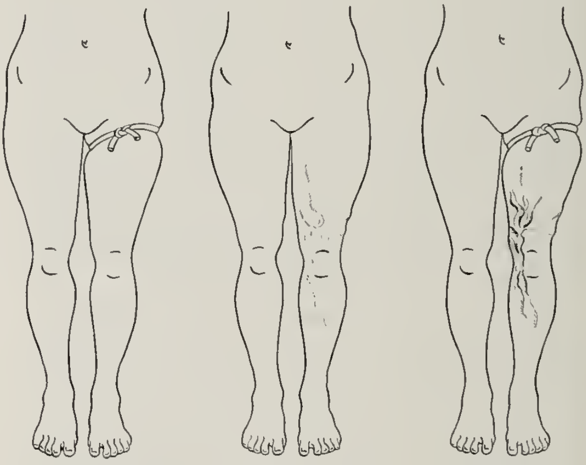


FIG. 5. A positive reaction, 35 seconds being regarded as the normal filling time.

As a result of all these tests, the following diagnoses may be made:

1. A simple dilatation or varicosity which does not involve the major veins.
2. An incompetent saphenofemoral valve.
3. An incompetent internal saphenous vein.
4. An incompetent external saphenous vein.

5. Incompetent communicating veins either with or without incompetent internal and external saphenous vein.
6. Partially or completely obstructed or incompetent deep circulation.
7. Adequate or inadequate arterial circulation.

THERAPY

The essence of the treatment of any patient having varicose veins is to eradicate the diseased veins in order to prevent development of the varicose state. When the varicose state exists, the treatment is an attempt to ameliorate or to eradicate it, a more formidable task.

A simple venous dilatation or a varicosity of any short segment, which does not involve the major portion of the internal or external saphenous vein, may be treated by sclerosing injections alone. However, one can almost anticipate that the end result will not be completely satisfactory, and that the varicose process will probably progress and will demand further treatment at some future date.

An incompetent saphenofemoral valve and incompetent internal saphenous vein should be treated by ligation, division and resection of the internal saphenous vein at the saphenofemoral junction, along with all branches in this area, and by the injection of sclerosing solutions. The importance of the ligation and resection of the branches which enter the saphenous vein before its junction with the femoral cannot be overemphasized. Recurrences which follow ligation are most frequently caused by the failure to ligate all of these branches. The injection of sclerosing solutions alone will probably not cure any case in which this derangement of the internal saphenous chain is prominent. Many other workers have confirmed this conclusion. Rakov[3] found 75 per cent recurrences following injection therapy alone, and 12 per cent following ligation plus injection within 10 months after treatment was discontinued. Hobbs[4] reports a recurrence rate of 60 per cent with injection alone, and a 10 per cent rate with ligation and injection. In a series of 340 cases, Jamieson[5] discovered these results with ligation and injection: 73 per cent "satisfactory," 14 per cent "improved," and 13 per cent "failed." Mahorner and Ochsner[1] state that 60 per cent of the cases treated by injection alone showed relapses, and that this ratio was reduced to 16 per cent when combined ligation and injection were employed.

The technic used by us for ligation and injection is illustrated in figure 6 (series 1–5). The inguinal region and thigh near the site of the operation is shaved. The skin is then sterilized and draped so as to expose the entire area. This operation may be done under local, general, or spinal anesthesia. The femoral artery is palpated just below the inguinal ligament and at a point 1 inch below the inguinal ligament, and ½ inch medial to the femoral artery an incision 2 inches long is made medially and parallel to the thigh-abdominal crease. This incision is carried through the skin and superficial fascia of the thigh. At this point all bleeding points are clamped and tied. Then an Allis clamp is placed on the upper and lower lips of the wound and retracted in their respective directions. With scissors and longitudinal dissection the saphenous vein is exposed. A hemostat is applied to the vein, gentle traction is made, and the vein is cleansed of the adjacent tissue. After a segment has been prepared, 2 clamps are applied, approximately 1 inch apart, and the vein is divided between them. By then placing a small retractor on top of the vein over the lip of the wound, by rather firm cephalad traction upon this retractor, and by distal traction on the clamp at the upper segment, the entire upper end of the internal saphenous vein and its tributaries are exposed at the fossa ovalis. All tributaries are exposed, doubly clamped, divided, and tied with fine silk or cotton. The stump of the saphenous vein which now remains is then dissected upward to the bulb of the internal saphenous vein. At this point, it is doubly ligated with silk and divided distal to the ligatures. It may be transfixed. The distal segment of the

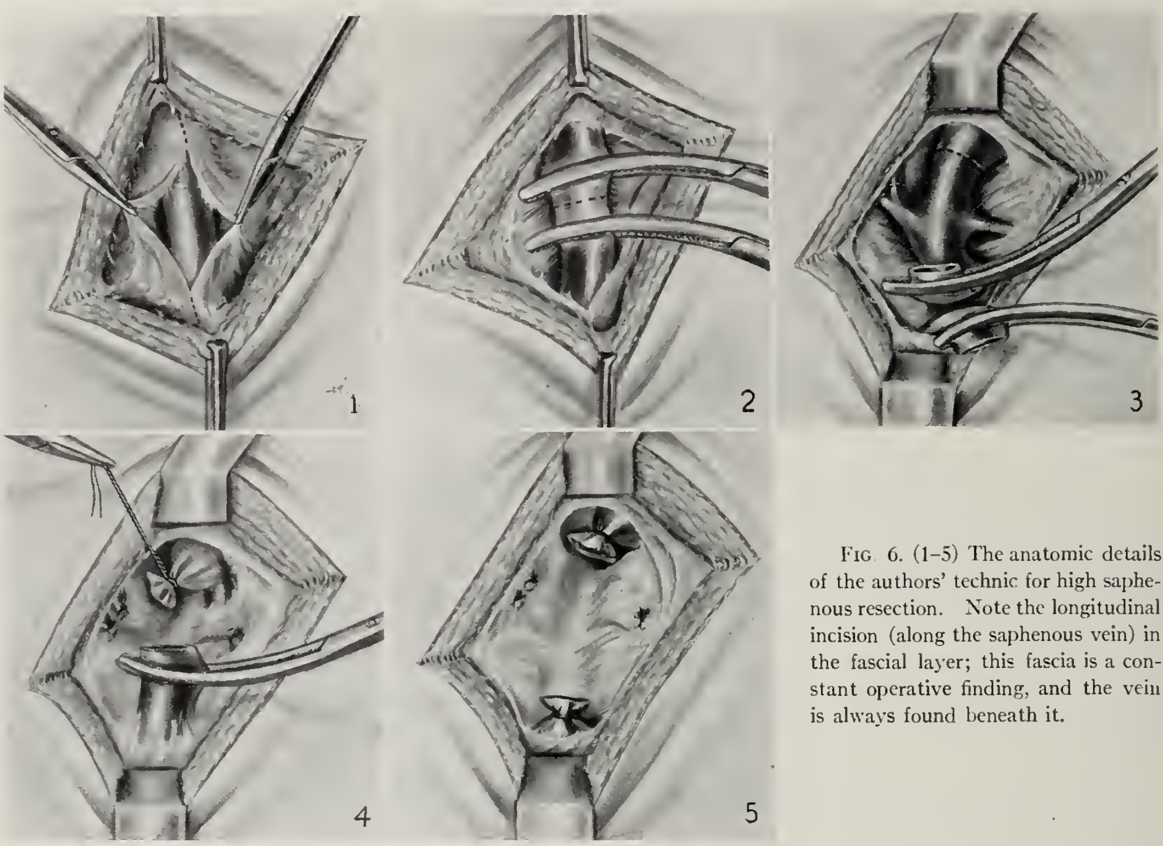


FIG. 6. (1–5) The anatomic details of the authors' technic for high saphenous resection. Note the longitudinal incision (along the saphenous vein) in the fascial layer; this fascia is a constant operative finding, and the vein is always found beneath it.

saphenous vein is dissected downward for 1 inch, doubly ligated, and divided above the ligature.

By this technic approximately 2 inches of the saphenous vein is removed. It may be mentioned at this point that the number of branches near the saphenofemoral junction is variable. It frequently varies from 2 to 5.

If the wound is perfectly dry, the superficial fascial layer is closed with fine interrupted silk sutures, and the same is done for the skin. Then the leg is elevated, and an elastic cotton bandage is applied from the foot up to the tibial tubercle. No injections are made at this time.

The patient is allowed to move about immediately after operation if local anesthesia is used and as soon as is plausible after general anesthesia. Three days after the operation the sutures are removed, and the first injection of 3 to 5 c.c. of sodium morrhuate is made just above the knee into the internal saphenous vein. Thereafter, at weekly intervals, the elastic bandage is lowered 3 inches, and the veins in the area exposed are injected (fig. 7). It usually requires 3 to 5

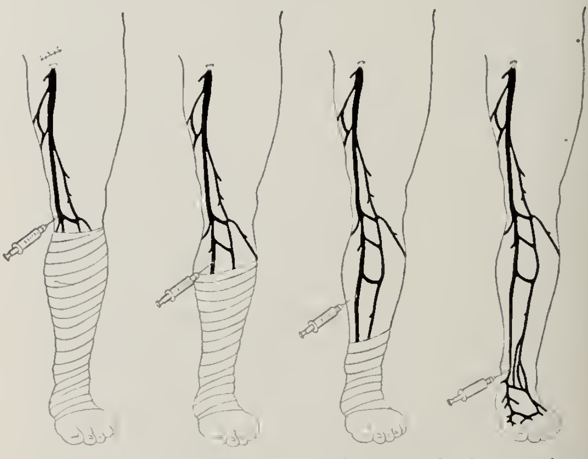


FIG. 7. Details of the postoperative sclerosis therapy; 3 to 5 c.c. of 5 per cent sodium morrhuate is used at each weekly injection.

injections for complete thrombosis of the internal saphenous vein. Patients do not experience a great deal of discomfort and can usually continue their normal routine. After complete thrombosis of all of the varicose veins the patient is brought back at regular intervals for a period of at least 6 months for observation and the detection of any new varicosities which require injection. After this period every patient should be seen 3 times a year to determine the presence of any varicosities which may need treatment.

There is no method of treatment which gives absolute assurance against recurrences or the formation of new varicosities in the veins which remain. In fact, it may be said with a sense of conservativeness that "once a varicose vein patient, always a varicose vein patient."

Our reasons for not injecting the distal segment at the time of operation are:

A. Two to 5 per cent of the cases that are ligated develop spontaneous, diffuse or patchy thrombosis in the chain.

B. Massive thrombosis from large injections causes a "very sore," inflamed and, at times, an edematous leg which frequently incapacitates the patient.

C. Massive thromboses may extend through the communicating veins into the deep system.

D. Emboli may occur from the extension of the thrombosis into the deep circulation.

E. Leakage of any of the sclerosing agent into the wound may prevent primary healing.

F. Sensitivity to the drug may exist, and the large dose used may cause a serious reaction.

The treatment of incompetent communicating branches, saphenofemoral valve and internal saphenous vein includes ligation of all of the tributaries at the saphenofemoral junction, ligation and resection of the saphenous vein at the saphenofemoral junction, and sectional ligation of the saphenous vein at the site of the incompetent communicating branches with subsequent injection of sclerosing solutions into the veins. The most common site for this particular incompetency is the communicating branch just above the knee. Occasionally it is necessary to ligate and to resect the internal saphenous vein b low the knee.

An incompetent external saphenous vein is treated by ligation of the major vein at its entrance into the popliteal, with subsequent injection of sclerosing solutions to obliterate the vein.

An incompetent external saphenous vein and communicating branches are treated in the same way as the group above, except for sectional ligation of the vein at the site of the incompetent communicating branch.

It is not within the province of this paper to discuss the treatment of incompetent deep venous circulation However, this general thought is important: that varicosities should not be ligated and injection therapy withheld except for an occasional segment when the deep circulation is found to be inadequate.

Deep venous inadequacy may also be determined by phlebographic investigation. Failure to visualize an adequate deep system by this method precludes any radical operation upon the superficial veins. (At this point we wish to note briefly that ligation or injection of a single feeder vessel in an eczematoid or ulcerated, edematous extremity may be performed safely and with gratifying results in selected cases, even though the deep venous return has been proven inadequate. This is an exception to the general principle stated above.)

The presence of an inadequate arterial circulation is usually a contraindication to drastic treatment of varicose veins.

This discussion would not be complete without a presentation of the treatment of varicosities which occur during pregnancy, or in the presence of other pelvic tumors. It is our plan not to treat actively any patient during pregnancy, but to encourage the wearing of elastic stockings throughout the entire period. Occasionally minor complications may occur in the varicosities which require treatment. We frequently wait 2 to 3 months after pregnancy before the treatment of any varicosities is begun. However, there are occasional exceptions to this rule. In the presence of other pelvic tumors which cause varicosities treatment of the varicosities should be a subsequent or secondary procedure.

Summary and Conclusions

1. The anatomy and normal physiology of the superficial veins of the lower extremity are presented.

2. The mechanism of the formation of varicosities is given, and an attempt is made to explain why some patients with varicosities have no complaints and complications, while others do have. These complaints and complications are a result of the stagnant superficial circulation, whether it be diffuse or localized. The term "varicose state" is applied to this abnormal condition of the circulation.

3. The history, both general and specific, and the tests to be performed, with their interpretations, for the accurate evaluation of the pathology and pathologic physiology of the deep and superficial venous systems are presented in detail. The Trendelenburg and Perthes' tests will in most cases give the information necessary for an intelligent evaluation of specific cases.

4. As a result of the history and tests, the following diagnoses may be made:

a. A simple dilatation or varicosity which does not involve the major veins.

b. An incompetent saphenofemoral valve.

c. An incompetent internal saphenous vein.

d. An incompetent external saphenous vein.

e. Incompetent communicating veins, either with or without incompetent internal and external saphenous vein.

f. Partially or completely obstructed or incompetent deep circulation.

g. Adequate or inadequate arterial circulation.

5. The plan of treatment for each of the above conditions with a description of the operative technic for high ligation of the saphenous vein and its tributaries, as well as the method of injecting the varicosities, is presented.

6. There is no method of treatment which gives absolute assurance against recurrences or the formation of new varicosities in the veins which remain, since it may be said that "once a varicose vein patient, always a varicose vein patient." However, of the methods available, the combination of high ligation of the saphenous vein and its tributaries at the saphenofemoral junction with thrombosis of the remaining veins gives the most hopeful results. One must remember to follow carefully every case of treated varicosities for a period of 1 year or more to insure the best possible result.

BIBLIOGRAPHY

1. Ochsner, A., and Mahorner, H.: Varicose Veins. St. Louis: Mosby, 1939.
2. Levin, A.: Personal communications to authors.
3. Rakov, P. H.: Treatment of varicose veins and varicose ulcers; experiences in 800 cases. New York State J. Med., 1939, **39**, 1569.
4. Hobbs, A. F.: Treatment of varicose veins and their complications. M. J. Australia, 1942, **1**, 776.
5. Jamieson, R. A.: High ligation in treatment of varicose veins. Glasgow M. J., 1942, **137**, 18.

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THE CLINICAL EXAMINATION IN THE RECOGNITION OF HEART DISEASE*

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HEART disease is the chief cause of mortality. It alone is responsible for the highest disability rate of all illnesses between the second and sixth decade of life. According to the National Health Survey, 8,000,000 persons are disabled by cardiovascular diseases each year.[1, 2] More than 152,000,000 days are lost annually. It is not surprising, therefore, that the public has manifested increased interest in disorders of the cardiovascular system. As a result, many people with and without heart disease have confronted the practicing physician with the question: "Do I have heart disease?" The answer requires a thorough examination and evaluation of all the findings on the basis of clinical experience.

It is the purpose of this discussion to focus attention on the value of the clinical examination and to exploit the symptoms and signs elicited to new levels of application and interpretation. In cardiology, as in other fields of clinical medicine, a thorough history and physical examination are the diagnostic foundation for the study of the patient.

THE HISTORY

The anamnesis is the most important part of the clinical examination. The value of the history depends upon the intelligence of the patient and the physician, the experience of the historian, and his attitude toward the patient. Since symptoms are usually subjective, they are dependent upon the sensitiveness of the individual and upon the stimulus. The role of each factor must be appraised in every case. It may even vary in the same individual at different times.

Often the symptoms elicited are dependent upon the circumstances for the examination, upon the physician, and the purpose of the examination. It is a common experience for many patients with organic heart disease to have no symptoms and those suffering with functional disorders of the heart to have many and varied complaints. In an insurance examination the individual may conceal pertinent information that would disqualify the applicant. The insurance examiner must then be subtle and ingenious as an historian. At times advanced heart disease may be asymptomatic, to be elicited only by a detailed examination utilizing all diagnostic modalities and provocative tests.

The majority of persons with heart disease, or those concerned about their heart, consult a physician because of pain, palpitation, and/or dyspnea. Any or all of these symptoms may have extracardiac causes for their origin. The present discussion is concerned only with these symptoms as they are produced by diseases of the heart and the great vessels.

Pain in the chest is a frequent reason for seeking medical attention. The discomfort varies with the underlying cardiac disorder in location, duration, radiation and subjective sensation. The precipitating factors and a detailed description of the pain may aid in the interpretation of the mechanisms for such distress.

Pain over the precordium is the most common complaint. It may be widespread to involve the entire precordium. Its intensity may vary from a dull ache or pressure to a sharp, lancinating discomfort. When it is severe, it may radiate to the left shoulder and down the left arm. It usually lasts 2 to 3 hours, sometimes all day and evening. It is rarely of short duration. This pain is not precipitated by exertion or when the patient is mentally or physically occupied; more often, it occurs during the inactive period of the day when the patient has time to think alone. Tenderness and hyperesthesia, especially over the left breast, is a usual concomitant finding. This discomfort may be relieved by infiltration with 2 per cent novocaine of the overlying integument. Rest and vasodilators are ineffective. This complaint may be associated with organic heart disease, but fatigue, worry and extreme anxiety are more often the factors behind the heart ache than heart disease per se. This type of pain is often more severe and yet is of no serious significance, whereas that of angina pectoris may be of less intensity and be of greater importance. The presence of this type of precordial pain is often reassurance that no serious heart disease exists.

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A far more significant type of cardiac pain is that located under the substernal region, the area covered by the necktie. It is rarely described as severe pain, but more often as a choking sensation, a cutting off of the breath, a pressure or tightness. It may on occasion be a little to the left of the sternum, less often to the right, very rarely over the precordium. It usually radiates to the left shoulder, down the medial aspect to the left arm and the little and ring fingers of that hand. It may radiate to the right shoulder, and when severe radiate along the carotid vessels and even to the mandible and teeth. It almost never radiates to the back. Substernal discomfort with radiation to the back is usually not due to coronary artery disease. The discomfort is usually precipitated by exertion, excitement, or a large meal. It may last 5 to 15 minutes as in angina pectoris. When it lasts an hour or more, it is usually due to myocardial infarction. Rest, oxygen, and vasodilators will usually result in prompt relief.

Short, sticky pain over the left breast aggravated by respiration is a frequent complaint in pericarditis when the mediastinal surface is affected. It is usually transient and lasts only a few days. When the effusion is large, a sensation of pressure may be described. Similar pain may be elicited in acute rheumatic carditis.

Dull, throbbing and continuous pain over the sternum, ribs or vertebral column may be due to destruction by pressure of aortic aneurysms. More often, aneurysms of the aorta are painless.

In the acute phase of dissecting aneurysm of the aorta the pain is sudden and severe, usually located in the substernal region and radiating down both arms, often into the neck, and almost invariably to the back. When the dissection is incomplete, the discomfort may vary in severity. Its location rarely changes; the pain is perhaps the most severe that can be experienced by man. On occasion, dissection may be asymptomatic.

Short, stabbing pain over the left breast, the sensation of fluttering, or of the heart turning over or stopping momentarily is frequently associated with premature systoles of auricular or ventricular origin, mainly the latter. The discomfort is fleeting and rarely produces disability; sometimes it may result in undue anxiety.

Palpitation or heart consciousness is a frequent complaint of a sensitive person whether the heart beats fast, slow, regularly or irregularly. The sensation is one of pounding or thumping over the precordium. It may be associated with precordial ache and may be felt in the head, abdomen, arms and legs. The common cause for palpitation is a simple increase in rate and force of heart action. The common benign arrhythmias are usually associated with this distress. An abnormal tachycardia or auricular fibrillation and flutter may cause similar discomfort.

Dyspnea, when of cardiac origin, is usually due to left ventricular failure. It may first manifest itself when walking up an incline; when failure progresses, walking on level ground may produce dyspnea. In the sedentary individual failure of the left ventricle may occur at night in paroxysms of nocturnal dyspnea or cardiac asthma. In some the equivalent for shortness of breath is replaced by weakness, fatigue, or lack of stamina. Others complain of insomnia or the inability to lie in bed without several pillows.

Sighing respiration is another form of dyspnea frequently seen in the hypersensitive individual. Such patients will insist that they are unable to fill the lungs with air, that the breath stops in the middle of inspiration, and that they fear some cardiac catastrophe is impending. The respiratory rate is usually normal, cyanosis is absent, and the symptoms are out of proportion to any objective signs. Relief is obtained by a sudden, deep sigh. This is an extremely valuable symptom in the differentiation of heart disease and an anxiety state. Heart pain, palpitation and dyspnea may be due to either heart disease or an anxiety state, but this type of sighing respiration is almost invariably of nervous and not of cardiac origin.

A little gentle prodding on the part of the historian may be necessary before the patient may yield the full symptomatology of his disease. Inquiry into other systems for symptoms may often be revealing. While headache, vertigo and tinnitus in themselves are not usually due to heart disease, they frequently are associated with cardiovascular disorders, unrelated to their severity. Faintness or syncope is rarely due to heart disease. Stokes-Adams syndrome, paroxysmal tachycardia, and an hyperactive carotid sinus may produce this symptom. Epistaxis may be a manifestation of active rheumatic fever as well as of chronic hypertension.

Hoarseness may be due to an enlarged left auricle of mitral stenosis or aneurysm of the aorta. Hemoptysis and cough are common in mitral stenosis and severe left heart failure. Pain in the epigastrium, nausea, vomiting, and hiccups may occur in posterior myocardial infarction and in pericarditis. Distress or pain in the right upper quadrant is not uncommon in severe heart failure due to engorgement of the liver. Severe abdominal pain may be due to embolism in a mesenteric artery, kidney or spleen, or as an early manifestation of active rheumatic fever. Constipation and even jaundice have been described in severe decompensation. Dysphagia may be due to mitral stenosis, a large pericardial effusion, aneurysm of the aorta, or congenital right aortic arch.

Polyuria and nycturia may be noted in far advanced hypertensive heart disease as evidence of renal involvement. Oliguria and anuria may develop during the precipitous fall in blood pressure in acute myocardial infarction. It is a serious sign and increases the gravity of the prognosis. Hematuria from renal emboli may be due to bacterial endocarditis or mural thrombi.

Irregularity in menstruation and amenorrhea are common findings in cardiac decompensation. Pregnancy increases the importance for careful evaluation of the cardiovascular system. Miscarriages are apt to occur during congestive failure. With far-advanced disease of the heart sexual desire usually is decreased.

Valuable information may be obtained from the careful and tactful inquiry about personal habits, the family, and business life of the patient. Often it may reveal the secret of the trouble, the cause, or the exacerbation of cardiac symptoms. What the general practitioner may lack in special training is balanced by his knowledge of the intimate history of his patient.

Inquiry into the past history may reveal the etiology of the underlying heart disease. Rheumatic fever, chorea, syphilis, high blood pressure, goiter, and nervous prostration are but a few examples. Acute myocarditis following specific infectious diseases occurs more frequently than has hitherto been thought. Compensation commissions may require a careful evaluation of the role played by trauma in producing cardiovascular symptoms. A surgical history is of little importance as a factor for producing cardiac symptoms. However, a panhysterectomy may precipitate an acute surgical climacterium and associated functional symptoms referable to the heart. It may also explain the unusual signs and symptoms of an acute cor pulmonale due to postoperative phlebothrombosis.

Physical Examination

The physical examination is of greater importance than the diagnostic aids that may be employed in subsequent studies. The general impression that the patient makes on the physician may be more valuable than any other finding of the examination. The gesture to indicate pain, an anxious glance, or a general remark may be invaluable in the proper handling of the case. The impressions may be many, and most of them are not recorded except more or less unconsciously in the mind of the examiner.

A record of the weight of the patient may be helpful in the future. An unexplained weight gain may be a subtle manifestation of cardiac decompensation; loss of weight when it is due to heart disease indicates a poor prognosis. Weight loss is frequently seen among cardiac patients in the latter months of life and reflects a failing circulation. The height and weight may be useful in the calculation of vital capacity, basal metabolism, and heart size by teleoroentgenogram or orthodiagram.

The temperature can be of diagnostic and prognostic value. A high sustained or subnormal temperature in myocardial infarction increases the gravity in prognosis.

In cardiac decompensation an elevated temperature above 101°F. usually implies some complication. In bacterial endocarditis failure of the temperature to subside with chemotherapeutic agents may indicate inadequate therapy, a resistant organism, or a poor prognosis. A sustained temperature for many weeks in rheumatic fever implies a severe infection or a complication.

The Corrigan pulse of aortic insufficiency, the plateau pulse of aortic stenosis, pulsus paradoxus of pericarditis with effusion or constrictive pericarditis, and peripheral arteriosclerosis are significant signs that one may elicit during the examination of the pulse. Unequal radial pulses and blood pressure in the arms may be due to local vascular disease or suggest an intrathoracic lesion. While recording the blood pressure pulsus alternans may be noted, a sign of left ventricular failure. Hypertension in a young person may be due to coarctation of the aorta. The blood pressure in the legs is usually lower than in the arms and is a valuable sign for detection of this congenital anomaly. Postural hypotension sometimes will explain the occurrence of frequent syncopal attacks. The blood pressure may also have prognostic value. Few patients are alive 5 years after the diastolic pressure of 140 is first recorded. A precipitous fall in the systolic blood pressure to 90 mm. Hg or lower in myocardial infarction, and failure to return after several hours, increases the gravity of prognosis. It also explains the oliguria and even anuria. Fluctuations in blood pressure during vascular crises or after changes in position, following sedation, or with cold pressor tests may have diagnostic as well as therapeutic implications.

The respiratory rate is normal in functional disorders of the heart; it is increased in congestive heart failure.

Signs of heart disease may manifest subtle stigmata far removed from the heart. These apparently insignificant signs may be the first clue to the presence of heart disease. Careful examination of the eye may reveal more information about the underlying heart disease than the examination of any other organ. The sparse distribution of hair of the eyebrow or the loss of hair in the outer corner of the eye may suggest the presence of myxedema and thus explain a reversible cardiomegaly. The widened palpebral fissure or the exophthalmos offers a probable cause for the auricular fibrillation. A unilateral enophthalmos (Horner's syndrome) may be due to pressure on the stellate ganglion by an aneurysm of the aorta. The pale conjunctiva suggests an anemia to be the cause of the systolic murmur. The petechiae in the conjunctiva readily offer an examiner an explanation for the chills, fever and sweats of bacterial endocarditis. The Argyle-Robertson pupil suggests the cause for the acquired aortic diastolic murmur, to be confirmed by blood and spinal fluid examinations. The retina may show petechiae of bacterial endocarditis; the millet-seed tubercles of disseminated tuberculosis may be the first etiologic clue for pericarditis. The tortuous retinal vessels and A–V compression with or without exudates caution the examiner against a functional diagnosis for the underlying heart disease. The substernal tightness is evaluated in a different light when these signs are present. Retinal vascular changes follow parallel changes in heart size and hence have prognostic implications. Keith and Wagener,[3] following their own classification of retinopathy, found 20 per cent of grade I, 36 per cent of grade II, 75 per cent of grade III, and 94 per cent of grade IV were dead 3 years after the initial examination. These statistics emphasize the valuable information to be gleaned by such an examination. Pulsation of the retinal arteries may be due to aortic regurgitation, patent ductus arteriosus, and thyrotoxicosis.

Careful appraisal of the veins of the neck may reveal valuable information about the right heart. Normally, on deep inspiration the external jugular vein collapses or diminishes in size; in right heart failure, tricuspid insufficiency, pericarditis with effusion, and obstruction of the superior vena cava above the azygos vein, the external jugular vein does not collapse but increases in size on deep inspiration. Pressure upon the right upper quadrant will result in an increased prominence of the jugular vein as a sign of incipient right heart failure. A positive venous pulse is indicative of tricuspid insufficiency. The absence of auricular waves is helpful in the differential diagnosis of ventricular tachycardia from other forms of paroxysmal rapid heart action.

The trachea may manifest signs suggestive of cardiovascular disease: the tracheal tug of aortic regurgitation and displacement of the trachea in mediastinal disease of vascular, neoplastic or inflammatory origin. An enlarged thyroid may serve to explain a cardiac arrhythmia due to thyrotoxicosis. Vigorous pulsation of the carotid vessels may be due to excitement or exertion, but also to chronic hypertension, thyrotoxicosis, and aortic regurgitation. Edema of the face and neck, cyanosis, and marked engorgement of the veins of the head and neck indicate obstruction of the superior vena cava.

Pressure over the carotid sinus may produce syncope and indicate the cause for previous attacks of loss of consciousness. Many patients have been erroneously diagnosed as having heart disease when the syncopal attacks were due to hyperactive carotid sinus. A hyperactive carotid sinus is frequently noted in cases of aortic stenosis and angina pectoris.

The Chest.—Asymmetry of the chest due to marked deformities of the spine and thorax may seriously interfere with the normal function of the heart and thereby produce pulmonocardiac disease. Prominent veins on the chest indicate interference with the centripetal flow of blood, usually due to extracardiac causes. Pulsating intercostal and scapular arteries are a late sign of coarctation of the aorta. Retraction of the interspaces in the left infrascapular and axillary region may suggest the presence of pericarditis or a very enlarged heart.

In the examination of the lungs persistent crepitant râles at both bases may be the only pulmonary sign of left heart failure. In heart disease complicated by pregnancy persistent crepitant râles at the bases is the first reliable physical sign of cardiac decompensation. Diminished breath and voice sounds at the right base due to hydrothorax is a common finding in severe heart failure, and dullness, tubular breathing and bronchophony at the left base may be due to compression of the lung by a large pericardial effusion, cardiac enlargement, or an enlarged left auricle of mitral stenosis. Bilateral pleural effusion is not a rare finding of cardiac decompensation. In addition, it is important to examine the lungs for signs of chronic pulmonary disease in which the heart may be only secondarily affected, as in chronic cor pulmonale.

Determination of the size of the heart is the most important single sign to be noted in the examination of the heart. An enlarged heart is never a normal heart. Left ventricular enlargement results in an apex impulse beyond the midclavicular line and displaced downward. Right ventricular hypertrophy is detected by palpation with the "heel" of the examiner's hand over the midsternum. Systolic depression of the sternum at this site is normal. With right ventricular hypertrophy there is a systolic elevation of the midsternum; the apex impulse is displaced to the left but not downward. As a rule, systolic thrills are rare; when present, they have great clinical significance. A systolic thrill in the third and fourth intercostal space close to the left parasternal line is usually due to an interventricular septal defect. In aortic stenosis a systolic thrill is present in the second and third intercostal spaces near the right parasternal line. It may be palpable only when the patient is upright and at the end of full expiration. A systolic thrill over the pulmonic area is usually due to pulmonary or infundibular stenosis, or to patent ductus arteriosus; a continuous thrill is more common in the latter defect.

In auscultation of the heart benign arrhythmias heard in the normal heart are of little clinical importance. In the diseased heart these same arrhythmias assume great significance. In a child with active rheumatic carditis the return of sinus arrhythmia indicates improvement; its disappearance may indicate increased activity. Premature ventricular systoles during an acute myocardial infarction may precede the onset of ventricular tachycardia or fibrillation and even death. The administration of quinidine at this time may be life-saving. Numerous premature ventricular systoles producing pulsus bigeminus are frequently a sign of digitalis intoxication.

Auricular fibrillation in acute myocardial infarction increases the mortality. It is a source for mural thrombi and embolization. Harrison[4] believes auricular fibrillation to be a "dry" manifestation of left ventricular failure. He recommends digitalization of all patients with coronary artery disease and auricular fibrillation. Levine's triad,[5] auricular fibrillation, mitral stenosis and history of rheumatic fever, is a practical clinical rule to follow. If any 2 are present, the third is probable. In auricular fibrillation of unknown etiology thyrotoxicosis should be considered.

In posterior myocardial infarction transient Stokes-Adams attacks may occur during the first two weeks of illness. Their presence, naturally, indicates a less favorable outlook.

During paroxysms of rapid heart action it is possible at the bedside to make clinical differentiations between the various types of tachycardia. In the simple tachycardia the rate rarely exceeds 150 or 160 beats per minute. It is regular and usually causes no distress. Pressure over the carotid sinus may temporarily slow the rate, the rhythm continues to be regular, and the rate usually returns to its original level.

In paroxysmal auricular flutter the auricles contract 250 to 350 times per minute with 2 to 1 or 3 to 1 A-V block. The ventricular rate rarely exceeds 180 per minute. The rhythm is slightly irregular, due to the varying A-V block. Carotid sinus pressure may increase the irregularity temporarily, but it does not interrupt the rhythm. Quinidine or mecholyl are ineffective.

In paroxysmal auricular tachycardia the ventricular rate is usually between 200 and 250 per minute. The first and second sounds are of equal intensity and produce a tick-tock rhythm. Carotid sinus pressure may abolish the rhythm instantly. The individual usually learns that holding the breath, pressure over the eyeballs, or traction on the tongue may stop the attack. At other times it may cease spontaneously.

In paroxysmal ventricular tachycardia the ventricular rate rarely exceeds 170 to 180 per minute. The rhythm is slightly irregular. The first heart sound varies in intensity from one period to another, thus seemingly exaggerating the irregularity. Carotid sinus stimulation is ineffective. This tachycardia implies serious heart disease; in coronary artery disease it may be the forerunner of ventricular fibrillation and death. It is important to recognize this arrhythmia promptly in order to administer quinidine. Digitalis is contraindicated and may prove fatal.

In auricular fibrillation the ventricular rate is usually 170 to 180 per minute, rarely exceeds 200 and usually produces no distress. It is easily recognized by the coarse irregularity.

An electrocardiogram may not always be available. Careful application of these points may be life-saving in such an emergency.

Protodiastolic gallop rhythm is a valuable sign; when present, it indicates left ventricular failure. Presystolic and mesodiastolic gallop rhythm have been described; their clinical significance is less certain. They are noted in cor pulmonale and bundle branch block.

Whenever the turbulence of the blood stream is increased beyond normal, murmurs may be produced. These may have structural deformity for their genesis. Local factors in the heart and great vessels or contiguous structures may, in like manner, produce murmurs without serious significance and are known as functional murmurs. The systolic murmur at the apex and base may be functional. It is usually not very loud and not widely transmitted; it is modified by changes in position, phases of respiration, and/or exertion. The systolic murmur that is heard at the apex and transmitted to the axilla and/or left base posteriorly is usually due to mitral insufficiency and implies the presence of organic heart disease.

Systolic murmurs at the aortic area may be due to aortic stenosis, simple dilatation of the aorta without aneurysm of the aorta, and hypertensive heart disease. They may also be transmitted from the pulmonic area.

As a rule, when a murmur is loud it may be heard over the entire precordium. The source of origin is usually the valve area where the murmur is heard loudest. Systolic murmurs over the pulmonic area are common. They are most often functional, but they may be due to pulmonary stenosis or patent ductus arteriosus. In the interventricular septal defect the systolic murmur is harsh and blowing and is usually heard in the third and fourth left interspaces close to the sternum. Systolic murmurs over the tricuspid area are extremely rare. Tricuspid insufficiency is usually diagnosed by peripheral signs and rarely produces a murmur over the valve area.

Diastolic murmurs at the apex are usually organic in origin, rarely functional. They are usually due to mitral stenosis or aortic regurgitation. The murmur of mitral stenosis has certain peculiar characteristics that make it difficult to detect if these properties are not appreciated. It is usually a rough, low-pitched murmur, sometimes indistinct even to the experienced ear. It never occurs with or immediately after the second sound, but after a definite time interval between the second and the succeeding first sound. It is localized over a small area and may not be heard a few centimeters away. It is heard best with the patient in the recumbent position and may be inaudible when he is upright. It may become more distinct when he is lying on the left side or after exertion. It is heard best with the bell and may be inaudible if a diaphragm is used. It is usually associated with a snapping first sound and an accentuated pulmonary second sound, and when far advanced manifests presystolic accentuation.

Diastolic murmurs at the base are due to aortic regurgitation and rarely to pulmonary regurgitation. It is usually heard best with the patient in the upright position with the diaphragm chest piece and at the end of expiration.

Continuous murmurs are usually extracardiac in origin. They are heard in patent ductus arteriosus and arteriovenous aneurysm.

It is important to stress the fact that many types of heart disease do not have murmurs. Congenital, hypertensive, thyrotoxic, and arteriosclerotic heart disease are but a few examples. The presence of murmurs is not incompatible with long life. Many persons with valvular heart disease can lead useful, productive, self-sufficient lives. It is the total examination that permits final evaluation of what the individual can do.

The Abdomen.—Examination of the abdomen may reveal significant signs relative to the cardiovascular system. Ascites of cardiac origin is due to right heart failure or constrictive pericarditis. The acutely enlarged liver may explain acute abdominal distress. On occasion its discovery may prevent an unnecessary abdominal operation in the child with acute rheumatic fever and in the adult with severe heart failure. A pulsating liver is a pathognomonic sign of tricuspid insufficiency. Bacterial endocarditis frequently produces splenomegaly; less often constrictive pericarditis may cause moderate enlargement of the spleen. Bilaterally enlarged and palpable kidneys may explain the cause of hypertension, pericarditis and azotemia on the basis of polycystic disease of the kidney.

The Genitourinal Tract.—The genitalia may reveal a penile scar of syphilis, also the cause for the aortic diastolic murmur. Chronic gonorrhea may be found in a patient with bacterial endocarditis. Genitourinary anomalies are sometimes associated with congenital cardiac defects.

The Extremities.—Edema of the extremities as an isolated sign is rarely due to cardiac decompensation. Phlebothrombosis in the lower extremities may be the source for pulmonary emboli and acute cor pulmonale, at times confused with posterior myocardial infarction. The presence of an arteriovenous aneurysm may explain the progressive cardiac enlargement. Evidence of impaired arterial circulation in the lower extremities, when bilateral, may be due to arteritis or generalized arteriosclerosis, a peripheral manifestation of systemic vascular disease in which the heart shares. Polyarthritis and rheumatic nodules are related to the cardiac murmurs elicited in the examination of the heart. Clubbing of the fingers may be due to congenital heart disease of the cyanotic variety. Progressive clubbing of the fingers, splinter hemorrhages, and tender fingertips are due to bacterial endocarditis. The absent knee jerks suggest syphilis as the cause of aortitis.

CONCLUSION

Time does not permit discussion in greater detail of other significant signs that may be of value in the cardiovascular survey. It is hoped that this presentation has indicated the value to be derived from a careful clinical examination. Such an examination will often establish the diagnosis without the need of additional laboratory studies. At other times it will suggest the probable diagnosis and indicate the type of laboratory procedures to be employed for final diagnosis. It will always establish rapport between the patient and physician to the advantage of both.

BIBLIOGRAPHY

1. Preliminary Reports, Sickness and Medical Care Series: Magnitude of chronic disease problem in United States. Bulletin 6, National Health Survey, 1938 (rev. 1939).
2. Boas, E. P.: The Unseen Plague—Chronic Disease. New York: J. J. Augustin Pub., 1940.
3. Wagener H. P., and Keith, N. M.: Diffuse arteriolar disease with hypertension and associated retinal lesions. Medicine, 1939, **18**, 317.
4. Harrison, T. R.: Failure of the Circulation. 2nd ed. Baltimore: Williams & Wilkins, 1939.
5. Levine, S. A.: Clinical Heart Disease, 2nd ed. Philadelphia: Saunders, 1940.

GENERAL REVIEW OF ALLERGY*

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DIAGNOSIS OF ALLERGY

ALLERGY is encountered frequently in general practice and all of the specialties. It has been estimated that 10 per cent of the population of the United States have major allergy, that is, allergy severe enough to warrant medical attention. It is important, therefore, that every physician should know how to recognize allergic manifestations in whatever form they present themselves.

History-taking. In the detection and study of allergy thorough history-taking is of paramount importance. A positive family history of allergy can be elicited in at least 50 per cent of allergic individuals. The child does not necessarily develop the same allergic disease as his parents, since it is merely the allergic constitution that is inherited, namely, the capacity to acquire sensitization to foreign substances. The stronger the family history, the higher the percentage of the offspring who develop allergy, and the earlier in life it manifests itself.

Persons with one form of allergy tend to develop other forms; for example, eczema in infancy leads frequently to asthma later in life. A personal history, therefore, of some other allergic disease (asthma, hay fever, eczema, urticaria or migraine) increases the likelihood that the present complaint is also due to allergy.

Persons allergic to food not infrequently report symptoms from the ingestion or handling of some particular food, or even from the odors of food cooking. Allergenic substances tend to produce symptoms at the point of contact with the body; hence foods may produce symptoms in any part of the alimentary tract. It is helpful to inquire whether the ingestion of any particular food or drug causes swelling of the tongue or lips, canker sores, itching of the roof of the mouth or of the throat, abdominal pain, nausea, vomiting, diarrhea, or even pruritus ani. Itching of the skin and urticarial and eczematous eruptions are also frequently attributable to food sensitization. Extreme dislike or distaste for certain foods may also be an indication of food allergy, instead of merely an aversion for certain articles of diet.

Allergy to animal epidermals is suspected when the patient reports an aggravation of symptoms following contact with animals, such as petting a cat or dog, riding horseback, visiting a stable or horse show, or attending a circus. The contact with animals may be an indirect one, such as with riding habits worn by others, or as in the case of laboratory technicians who work with rabbits or guinea pigs and bring home on their hair or clothing sufficient particles of animal dander to produce symptoms in other members of their household. The patient should also be asked whether he has ever suspected bedding, namely, sleeping on feather pillows, hair mattresses, feather beds, or with down comforts or woolen blankets.

Exacerbation of symptoms from exposure to house dust, as in dusting, sweeping, or housecleaning, is commonly complained of by allergic individuals. House dust, being both ubiquitous and perennial, is one of our most important allergens. Although a high degree of specific sensitivity may exist to house dust, in some cases in which dust is suspected it is merely mechanically irritating to the respiratory mucous membranes.

Sensitivity to orris root may be suspected when symptoms are produced by exposure to cosmetics, such as powders, perfumes, sachets, bath powders, or dry shampoos. Orris-sensitive individuals are made worse by visits to beauty parlors or crowded places like theaters or ballrooms. Balyeat called attention to the fact that itching of the eyes is almost pathognomonic of sensitization to some air-borne substance, and itching of the eyes is a common manifestation of orris root sensitization. Cosmetic manufacturers are becoming more allergy-conscious now and are making commercially available hypo-allergenic toiletries which are free of orris and other common sensitizers.

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Allergic patients may give a history of hay fever or asthma symptoms from exposure to insecticides which contain pyrethrum, a member of the composite family related to ragweed. Pyrethrum is also a potent skin sensitizer, and I have encountered some troublesome cases of dermatitis due to this cause.

Patients may have noted allergic manifestations from clothing, such as silk, linen, wool, or cotton clothes, camel's hair coats or scarfs, fur coats or neck pieces, feather trimming on hats, etc. I recently encountered a lady highly sensitive to cottonseed, whose allergenic depot turned out to be cotton pads in the shoulders of her dresses. Various dyes in clothing, paraphenylendiamine for one, may produce allergic irritation of the skin.

Seasonal hay-fever patients frequently attribute their trouble to certain plants, flowers, or weeds, such as trees, grasses, roses, ragweed, or goldenrod.

Hay fever or asthma limited to some definite season, as spring, summer, or fall, is important information to obtain: early spring, incriminating trees; late spring or early summer, grasses or plantain; and fall, the ragweeds. Bacterial cases also tend to be worse in the changeable weather of early spring and late fall, as well as in the winter coincident with the increase in respiratory infections.

Allergic individuals at times associate their attacks with certain houses or localities, and may erroneously attribute them to unfavorable climatic conditions, whereas they are actually due to something in the environment, perhaps a domestic pet or some offending plant. Leaving a home where there is a cat, dog, or parrot may give surcease from asthma or hay fever. Ragweed victims who joined the armed forces got complete relief from hay fever and asthma in Europe where there is little or no ragweed. Fall-blooming elm trees in the South and Southwest may be responsible for hay fever and asthma in August and September that is confused with ragweed sensitivity. These same patients would have trouble in the spring of the year if visiting in the northeastern states, from the early blooming elms there.

Inquiry should be made about allergy to drugs, such as aspirin, quinine, sulfonamides, or penicillin, since the results of the use of these drugs in such individuals may be disastrous or even fatal, and skin tests in this category are notoriously unsatisfactory.

Paroxysmal sneezing is another indication of sensitization. The late Dr. W. T. Vaughan commented that he had never seen anyone but an allergic individual sneeze 10 or 12 times without stopping.

Profuse watery discharge from the nose alternating with periods of nasal stoppage is a frequent complaint of both seasonal and perennial allergic patients.

Physical examination. After completing the history, a careful inspection and physical examination of the patient may yield additional information suggestive of allergy, such as the following manifestations:

Red, tearing eyes, which are sensitive to light and frequently rubbed.

Rubbing and twitching of the nose. An upward rubbing of the nose has been termed "the allergic salute."

Depression over the antra in children from chronic nasal allergy and consequent failure of development of the sinuses.

Wheezing respiration, chiefly expiratory in type.

Prominent scapulae.

Barrel chest of emphysema.

Use of accessory muscles of respiration.

Depression of lower ribs.

Low blood pressure.

Pale, bluish-gray nasal mucous membrane, which may appear boggy or water-logged.

Nasal polyps.

Pallor of the soft palate.

Urticarial or eczematous skin lesions.

Laboratory tests. Following the general examination, additional evidence confirmatory of allergy can be obtained from laboratory tests other than the specific skin tests.

Nasal and conjunctival smears, which are stained and examined as for differential leukocyte counts, show a preponderance of eosinophiles in allergic conditions. Hansel particularly has stressed the importance of nasal smears in diagnosing allergy.

Blood eosinophilia is also strongly suggestive of allergy, but may be present in some nonallergic conditions.

A positive leukopenic index, that is, a definite drop in the total leukocyte count following the ingestion of some offending food, tends to accompany food allergy. The reliability of this test has been questioned by Loveless and others, and I personally do not use it.

Low blood sedimentation rates suggest allergy. Lower sedimentation rates are encountered in uncomplicated allergy than in any other condition I know of. High blood sedimentation rates are invaluable, of course, in the detection of serious infections, malignancy, and other nonallergic diseases.

A normal Weltmann coagulation band of 6 is usually found in uncomplicated allergy, whereas a shift to the left indicates infection and a shift to the right some fibrotic process or liver trouble.

Skin tests. Skin tests, when positive, settle the diagnosis of allergy and are invaluable in determining the specific allergens. The literature from some commercial houses would lead one to believe that the purchase of a skin-testing set would enable anyone to practice allergy. Buying a skin-testing set will not transform the ordinary physician into an allergist any more than the installation of an X-ray machine would make a radiologist. Considerable skill and experience are required for proper performance and interpretation of skin tests.

The so-called "scratch" or cutaneous method is the best and safest for routine testing, since it is simpler, less painful, and does away with the false reactions and danger accompanying the intradermal method. Rather than scratches, small linear incisions about $\frac{1}{8}$ inch long are made with the tip of a small, sharp scalpel, through the outer layers of the skin but not deep enough to draw blood.

The back is the best site, and the flexor surface of the arms the next best for the application of the skin tests. Since there is more room on the back, the tests do not have to be put so close together; the patient is lying down comfortably and hence cannot faint, which occasionally happens when a patient is tested sitting up; and most important of all, tests applied to the back tend to give larger reactions than when put on the arms or legs.

In cutaneous testing with dry, powdered proteins I have found the best solvent to be tenth-normal sodium hydroxide diluted with an equal amount of pure glycerine. The 50 per cent glycerine content prevents the tests from drying up during the reacting period and, as Coca has pointed out, increases the efficiency of the cutaneous tests to approximate that of intradermal testing. The neatest and quickest method for cutaneous testing is to have the glycerinated diagnostic extracts in small glass vials equipped with dropper applicators in the form of capillary glass tubes with rubber-bulb stoppers, which were introduced by Hollister-Stier Laboratories. Concentrated glycero-saline pollen extracts (preferably 10 per cent) give larger skin reactions than tests with dry pollens.

In the presence of a strongly positive history of allergy to some particular substance, intradermal testing with an extract of that substance is unnecessary and dangerous, since it is likely to produce a constitutional reaction which may prove fatal. A cutaneous test with the same substance, however, would be equally diagnostic and perfectly safe.

The principal technical fault in performing intradermal tests is the injecting of too much fluid, which leads to false reactions. Only sufficient extract should be injected between the layers of the skin to produce a wheal about $\frac{1}{8}$ inch in diameter. This requires only 0.02 or 0.03 c.c. of liquid, not 0.10 c.c., as some writers recommend. By watching the size of the wheal produced by the fluid entering the skin, one can ignore the markings on the syringes, since equal amounts of fluid produce the same sized initial wheals.

Comparative skin tests on known sensitive individuals with all of the available commercial allergens demonstrated to me that some of them were highly potent and others inert. It becomes almost essential, therefore, that those of us who specialize in allergy prepare our own extracts in order to ensure control over their potency and reliability.

In evaluating positive skin reactions conformity with the patient's history is the best guide to follow. When reactions occur to a number of different substances, the most important offenders usually give the largest and most irregular wheals, and these primary reactors tend to persist in the form of pink, itchy areas for hours or even a day or more following the application of the tests, whereas with the less important reactors the wheals quickly fade.

Skin tests are invaluable but not infallible, and the occurrence of false-positive and false-negative tests is admitted by all allergists. Certainly I would not want to practice allergy without the invaluable diagnostic information obtainable from the correct interpretation of properly applied skin tests.

Positive skin reactions may denote either past, present, or future sensitivity. The skin has a remarkable "memory," and just as a positive tuberculin reaction may be elicited years after the disease has ceased to exist, so may positive skin reactions to foods and other substances persist when they are no longer clinically significant. For example, egg sensitization in infancy may disappear with the passage of time and the person be able to eat egg with impunity, and yet a positive skin reactivity to egg may still be demonstrable. Present sensitization is the usual significance of positive skin reactions, and needs no further discussion. Occasionally we observe patients who give positive reactions to grass or ragweed pollens a year or two before they manifest any symptoms that can be attributed to this sensitization, which would be an example of future sensitivity in evaluating the premature skin reactions.

Patients are not infrequently encountered with what I would term pseudoallergy. These individuals attribute every form of vague ailment to allergy, usually to certain foods, which careful study fails to substantiate. This erroneous impression is often started by some doctor supposedly finding them sensitive to a number of different substances, and is aided and abetted by what they have read and heard about allergy. These patients come in armed with a lengthy list of alleged reactors, chiefly foods, which findings cannot be confirmed even after the most thorough and careful retesting. Such patients are usually so obsessed with the idea of being allergic to a large number of foods, that they nearly starve themselves in eliminating essential and actually harmless foods. One example should suffice.

A middle-aged woman with chronic urticaria had been treated elsewhere for 3 years on the basis of multiple food sensitization, and had been kept on narrowly restricted diets for so long that she was considerably undernourished. She also had pernicious anemia. Since retesting revealed no evidence of allergy, a fully balanced diet was resumed. Recognition of achylia gastrica associated with the primary anemia called for the administration of dilute hydrochloric acid, which resulted in prompt and permanent disappearance of the urticaria.

Indirect testing or passive transfer by the method first described by Prausnitz and Küstner is useful in demonstrating the presence and quantity of atopic reagins in the blood of allergic individuals, thus making it possible to perform sensitization tests even on those individuals who are not suitable or available for direct testing. The passive transfer technic also serves a number of other specialized uses in the technical study of allergic disease.

Ophthalmic tests. It is fortunate for the allergists that most all of the patients with mucous membrane sensitivity manifested as hay fever also have a concomitant skin sensitization to the same substances. Since an occasional hay fever patient, however, has a localized sensitization of the conjunctival and nasal mucous membranes with no accompanying skin sensitization, both cutaneous and intradermal tests are negative in spite of a definite seasonal history. In such cases ophthalmic tests with the suspected pollens are indicated, but these tests must be performed with considerable care. The small amount of dry pollen that is used in making the test should not be allowed to stay in the eye for more than a few minutes, and any resulting positive reaction should be promptly neutralized by the instillation of 1:1000 epinephrine lest unpleasant edema develop.

ASTHMA

Bronchial asthma may be defined as a paroxysmal form of dyspnea, chiefly expiratory in type, accompanied by wheezing, and due to sensitization to some foreign substance or substances usually protein in nature.

Differential diagnosis. Chevalier Jackson has well said that "all is not asthma that wheezes." It is important therefore to differentiate true asthma from all other conditions with which it might be confused.

The first of these is asthmatic bronchitis, which is primarily bronchitis and secondarily asthma and hence is associated with and follows respiratory infections. This condition has probably been discussed sufficiently in my previous writings on bacterial asthma.

As you are all trained internists it should be sufficient to enumerate the other conditions that may be mistaken for bronchial asthma:

Cardiac asthma or dyspnea.

So-called thymic asthma.

Foreign bodies in the air passages.

Pulmonary tuberculosis, including chronic fibroid phthisis.

Pneumoconiosis, miners' asthma, etc.

Enlarged tracheobronchial lymph glands.

Aortic aneurysm.

Pulmonary neoplasms. (Cancer of the lung is usually not diagnosed until it is too late to save the life of the patient. One must be on the lookout when there is marked and progressive loss of weight and strength out of all proportion to the symptoms of asthma. In the X-ray studies a significant finding is the abrupt termination of a bronchus as observed in endobronchial carcinoma. It is pathetic to wait until these malignant growths metastasize before diagnosing them.)

Hysterical dyspnea (sighing but no wheezing).

Pneumonia, which may be difficult to differentiate from asthma in children.

Emphysema.

Bronchiectasis.

Treatment. The ideal treatment of bronchial asthma, as in all forms of allergic disease, is complete avoidance of the causative allergen, when this can be accomplished. When avoidance is impossible or incomplete, specific desensitization or hyposensitization is the ideal therapeutic procedure. The more the treatments are "tailor-made" to suit the individual patient, the better are the results.

When a patient reacts to a number of unrelated substances, it is helpful to know that the first thing is usually the worst thing. For example, a patient with fall hay fever who later develops asthma toward the end of the ragweed season, which asthma eventually becomes perennial in character, probably still requires ragweed hyposensitization as the most important part of his therapy.

In administering hyposensitizing injections all of the doses should be regulated and progressively increased so as to produce a 24-hour positive local reaction following each treatment. Bacterial vaccine doses should be so regulated as to produce 48-hour positive local reactions. Results from hyposensitization are somewhat proportional to the local reactions obtained. When no reactions follow the injections, either the proper extracts have not been selected for treatment, or the doses are not sufficiently strong.

Osler in his "Principles and Practice of Medicine" 30 years ago recommended potassium iodide in bronchial asthma, and it is still a useful drug in the treatment of this disease. It may be prescribed as the saturated solution, 5 to 20 minims in $\frac{1}{2}$ glass of water 3 times daily about $\frac{1}{2}$ hour before meals, or combined with other drugs. Iodides are secreted in the bronchial tree and act by thinning the tenacious sputum, thus aiding expectoration. The potassium ion has also been shown to possess bronchial-dilating properties.

Epinephrine is still the most valuable hypodermic drug we possess for coping with acutely severe asthmatic attacks. An objectionable feature from the use of epinephrine is the unpleasant tremor, which can be minimized by reducing the doses to the smallest effective amount. I accidentally discovered that these epinephrine tremors can be obviated in some cases by the previous hypodermic administration of about 50 mg. of thiamine hydrochloride.

In spite of the introduction of the newer antiallergic drugs, ephedrine is still very valuable in the symptomatic treatment of bronchial asthma, either alone or in combination with theophylline and phenobarbital. The adult dose of ephedrine sulphate or hydrochloride is from $\frac{3}{8}$ to $\frac{3}{4}$ grain every 4 to 8 hours. It is interesting to note that ephedrine definitely stimulates the central nervous system when administered to adults but seems to exert a sedative effect when given to small children.

Inhalation of vaporized 1:100 epinephrine solution has been a boon to innumerable asthma sufferers. Unfortunately some of the vaporizers on the market are little more than toys, since they do not deliver enough vapor to be effective. One of the best is manufactured by the Vaponefrin Company. Of the less expensive nebulizers, the DeVilbiss no. 40 is adequate. The epinephrine vapor should be inhaled through the open mouth and never through the nose. The addition of 10 per cent glycerine to the 1:100 epinephrine aids in nebulization of the solution and tends to prevent dryness of the throat. The 1:100 epinephrine solutions should never under any circumstances be used for injection purposes.

Butanefrine, a newer synthetic, seems to have some advantages over epinephrine hypodermically in that it produces less tremor. The dose is $\frac{1}{2}$ to 1 c.c. of a 1:500 solution intramuscularly.

In my experience the best and safest form of nonspecific protein therapy has been 50 per cent peptone solution, prepared after the method of Schiff.

Status Asthmaticus

Status asthmaticus or constant intractable asthma is a real medical emergency and hospitalization of the patient is usually indicated.

All former medication should be stopped, since it is obviously ineffective and may be doing harm. For example, when the patient is adrenalin-fast, there is no advantage in giving any more epinephrine for the present. In some asthmatics adrenalin seems to dry up the bronchial secretions, thus aggravating the very condition we are trying to relieve. When ephedrine is ineffective, its continued use overstimulates the heart and central nervous system and thus is harmful.

The asthmatic patient in status is usually dehydrated and undernourished; therefore, the slow intravenous administration of 500 or 1,000 c.c. of 10 per cent glucose in saline may prove definitely beneficial.

Aminophylline, $7\frac{1}{2}$ grains intravenously, frequently gives dramatic relief and may even be a life-saving measure in severe asthma. Aminophylline is commercially available in $7\frac{1}{2}$ grain-20 c.c. ampules suitable for intravenous use, and should be injected slowly with the patient preferably in a recumbent position. The 7½ grain-2 c.c. aminophylline ampule for intramuscular use may also be used intravenously by diluting it in the syringe with 20 c.c. of sterile 50 per cent glucose solution; this in my experience is even more effective than the plain aminophylline solution. Aminophylline given intravenously causes a subjective hot flushing of the skin, palpitation of the heart which may be accompanied by throbbing pulsation in the head, headache, and sometimes nausea and vomiting. All of these unpleasant symptoms are somewhat contingent upon the rapidity of injection.

The continuous use of oxygen, either by tent or nasal catheter, is indicated whenever cyanosis is present. The use of helium 80 per cent and oxygen 20 per cent, as recommended by Barach, is more effective in relieving asthma than straight oxygen, and is best administered with the B.L.B. mask and rebreather bag.

Hypertonic glucose, 50 c.c. of 50 per cent sterile solution given intravenously, may be helpful and probably acts by reducing the edematous swelling of the bronchial mucous membrane. The addition of 0.5 c.c. of 1:1000 epinephrine solution to the hypertonic glucose may enhance its effect.

The late Dr. Duke called attention to the fact that 5 or 10 grains of aspirin plus 1 or 2 ounces of whiskey would at times relieve asthmatic attacks refractory to other medication. However, aspirin is a dangerous drug for asthmatics because of the possibility of idiosyncrasy to it. Severe and even fatal reactions have followed the taking of only 1 or 2 aspirin tablets by persons allergic to this drug. I have encountered several cases of severe status asthmaticus accompanied by marked cyanosis which were due to the ingestion of a small dose of acetylsalicylic acid. The history is the best guide here, since the individual usually knows whether aspirin has disagreed in the past, and skin tests with the drug are negative. Acetylsalicylic acid is a nonprotein substance that apparently has to combine with blood or tissue proteins to form the allergenic compound. Frank Coke of England called attention to an unusually stubborn type of asthma in patients with negative skin reactions, nasal polyps, and idiosyncrasy to aspirin.

The sulfonamide drugs and penicillin are of considerable value in infectious asthma. The presence of fever, leukocytosis, and purulent sputum are indications for their use.

Bacterial infection and bacterial allergy play an important and frequently unappreciated role in the causation of asthma. Autogenous bacterial vaccine-filtrates are the ideal agents in bacterial asthma, accompanied, of course, by desensitizing injections with extracts of specific inhalants whenever indicated. Properly selected stock vaccines may also be useful.

The use of morphine is contraindicated in asthma, and most of the deaths in asthmatics have followed its use. Morphine slows the respirations of the asthmatic patient who is not getting enough oxygen with each breath, and so tends to produce an anoxia of the brain. Morphine also checks the cough reflex when the asthmatic individual's desperate need is to expectorate the thick gummy mucus which is plugging the bronchial tubes.

Demerol is a much safer drug than morphine in asthma. Fifty mg. or 1.0 c.c. of the ampule solution intramuscularly, and repeated if necessary, may give much needed rest and relaxation to the exhausted asthmatic.

Ether in oil by rectum may be of use in terminating status asthmaticus and restoring responsiveness to epinephrine. Maytum's formula seems to be a satisfactory one, namely, 1 ounce of a mixture of equal parts of ether and olive oil for each 20 pounds of body weight. The ether and olive oil should be thoroughly mixed, gently warmed, and administered slowly through a rectal tube.

X-ray therapy over the chest, as advocated by Maytum and Leddy of the Mayo Clinic and Balyeat and his associates, is very valuable in stopping severe chronic asthma, but should be used as a last resort because of the definite limitation on the total amount of radiation that can be given to the individual patient.

Fever therapy may be helpful at times in terminating a refractory asthmatic state. Carefully regulated doses of typhoid vaccine given intravenously is probably the simplest method of producing artificial fever. However, no artificially produced fever is as effective in stopping asthma as a spontaneously occurring high fever accompanying some other intercurrent disease.

HAY FEVER

Seasonal hay fever. We know, of course, that hay fever is due to anemophilous or wind-pollinated plants, and that entomophilous or insect-pollinated plants with their brightly colored flowers and sweet odors have little or nothing to do with the disease.

Intensive preseasonal treatment, with the gradually building up to maximum doses just before the season, is the ideal form of treatment for seasonal hay fever. When an adequate dosage level is attained before the season, further increases during the season are likely to bring on or aggravate hay fever symptoms. The selection of the proper treatment extracts, and the regulation of the separate doses, must be highly individualized to suit each particular patient for consistently satisfactory results.

When time permits, hyposensitizing injections are given at weekly intervals, more frequently when the time before season is short. The doses should never overlap, however; that is, a treatment must not be given until the local reaction from the previous dose has disappeared. It is interesting to note the origin of the weekly treatment interval which has been almost universally adopted for hyposensitizing injection. The clinic of Noon and Freeman in London, England, where the first injections of hay fever pollen extracts were administered, was open only once a week.

When no treatment or insufficient treatment has been given before the season, carefully regulated co-seasonal doses of the specific pollen extracts are definitely helpful.

One interesting "by-product" of specific pollen injections for hay fever is relative freedom from colds and sinus trouble the following winter, which is probably due to a nonspecific stimulation of the immunity mechanism.

Constitutional reactions are the bugbear of pollen therapy and occur rather frequently in inexperienced hands. Considerable care and judgment should be used in regulating the individual doses, particularly when change is made to a more concentrated extract or to a new batch of extract. Also, precautions should be taken to prevent the extract from being injected into a vein by retraction of the syringe piston before the extract is deposited in the tissues and by pressure with a pledget of cotton over the site of injection as the needle is withdrawn in order to seal off any blood vessels that may have been punctured and thus prevent back-seepage into the circulation. Constitutional reactions are due either to too strong a dose or too rapid absorption of the proper dose.

In the past I have called attention to another type of constitutional reaction that may occur following the administration of bacterial vaccines. This reaction does not occur until several hours following the injection and consists of a chill and generalized aching and malaise, followed by fever, suggesting an attack of grippe. All of these symptoms, however, disappear by the following day. Such constitutional reactions are undoubtedly due to some of the bacterial protein entering the blood stream too rapidly and can be reproduced by intentionally injecting typhoid vaccine intravenously. On the other hand, constitutional reactions from pollen injections occur immediately and consist of varying degrees of urticaria, hay fever, asthma, and shock.

Perennial hay fever. Nonseasonal or perennial hay fever is quite prevalent and frequently taxes the diagnostic and therapeutic ability of the allergist, rhinologist, or internist. Time will not permit any extensive discussion here, but I would like to call attention to the nose drop menace. We are all familiar with the risk of habituation in prescribing nose drops containing cocaine for a patient with chronic nasal symptoms. Now we are faced with another danger in prescribing privine nose drops. This potent vasoconstrictor produces prompt and gratifying shrinkage of the swollen nasal mucous membrane, but this may be followed by a rebound reaction or secondary turgescence that is worse than the original condition. This leads to the excessive and frequent use of privine, resulting in a condition of more or less complete and constant blockage of the nose. It is essential to stop the use of nose drops entirely in these very uncomfortable individuals, and in some instances when this is done the patient's nose will return to normal without any other treatment.

FOOD ALLERGY

All I care to say about food allergy here is to call attention to the fact that sensitization to certain foods, such as nuts, may produce attacks simulating acute appendicitis. One patient of mine was needlessly operated on for the removal of an edematous appendix loaded with eosinophiles. I have had difficulty in preventing operation in other similar cases. Such cases can be diagnosed by an allergic history, blood eosinophilia, absence of neutrophilic leukocytosis, and response to adrenalin or ephedrine.

ECZEMA

Atopic eczema, by the character and distribution of the skin lesions, the presence of positive scratch or intradermal skin reactions, and the presence of atopic reagins (Coca) in the blood, can be differentiated from contact dermatitis. Contact dermatitis with its vesicular skin lesions and positive patch tests is typified by the commonly encountered poison ivy or Rhus dermatitis.

Allergic dermatitis from silk, although less frequently encountered than prior to our war with Japan, is interesting in that the skin lesions are produced by inhalation of fine particles of silk from the air rather than by contact of silk with the skin. These patients give positive scratch and intradermal reactions when skin-tested with potent silk protein extracts but give negative patch tests with silk.

Ragweed pollen is of interest in that it contains a water-soluble fraction which acts by inhalation to produce hay fever and asthma, and an oil-soluble fraction which is present also in the ragweed plant and acts by contact to produce contact dermatitis.

The causes of contact dermatitis in industry are innumerable, but among the important contactants encountered in nonindustrial practice may be pyrethrum in insecticides, nickel, para red in rotogravure, paraphenylendiamine in black dyes, and nail enamel. Nail enamel usually produces dermatitis around the eyes and at times on the face and neck but does not affect the fingers.

An itching dermatitis may be due to sensitivity to some drug such as phenobarbital which the patient is taking to relieve the pruritus and accompanying nervousness.

VERNAL CATARRH

Vernal catarrh may be differentiated from seasonal hay fever by limitation of symptoms to the eyes, and, although attacks occur annually coincident with warm weather, the season is not so sharply limited to any particular pollinating period as it is in hay fever. Vernal catarrh is also accompanied by the characteristic lardaceous or "chewing gum" secretion, and typical cobblestone formation may be noted on the under surface of the eyelids. Cooke has recommended tonsillectomy and autogenous vaccine therapy for these patients. I have obtained apparent cure of vernal catarrh by treatment with autogenous vaccines in combination with pollen extract mixtures according to seasons and locality even with completely negative skin reactions. Bowen has suggested that vernal catarrh may be a form of contact reaction due to pollens.

PERIARTERITIS NODOSA

This fatal disease is seldom diagnosed except at autopsy. It is probably due to irreversible allergic reactions involving the arteries of the various organs and tissues of the body. It may be suspected by its bizarre and changing symptomatology and high blood eosinophilia. The only positive antemortem diagnosis is made by biopsy of nodules from affected tissue.

Rickettsial and Virus Vaccines

Severe and even fatal reactions have occurred from the administration of the vaccines of tick fever (Rocky Mountain spotted fever), typhus, yellow fever, or influenza (types A and B) to egg-sensitive individuals. These rickettsial and virus preparations are grown in the chick embryo or eggyolk sac and should never be given to persons who are definitely allergic to egg or chicken.

Sensitivity to Liver Extracts

Some patients with pernicious anemia unfortunately develop sensitization to liver extracts which are so essential in the treatment of the disease. When changing the brand and type of liver extract does not remedy the situation desensitization should be attempted. When this fails, folic acid should be substituted, although it does not seem to prevent the central nervous system changes as effectively as liver extracts.

Poison Ivy

Prophylactic injections are very effective in preventing poison ivy dermatitis, provided adequate doses of a potent extract are given. Some years ago I patch-tested all of the available commercial poison-ivy extracts on known susceptible individuals. Some of these commercial extracts were highly potent, others moderately so, and some were completely nonreactive.

Unless the doses of poison-ivy extract during an attack of poison-ivy dermatitis are carefully regulated they may aggravate and spread the trouble, although I have frequently obtained gratifying relief from the specific injections. Some patients report satisfactory relief from oral poison ivy-extracts.

Urticaria

In an isolated attack of acute urticaria inquiry should always be made as to whether any foreign serum has been administered recently.

Insect bites may produce intensely pruritic urticarial wheals. Scabies may also simulate true urticaria.

Since acute urticaria is frequently due to reaction to some food, a brisk purge is indicated.

The use of epinephrine hypodermically is the best treatment for severe attacks of urticaria or angioneurotic edema. Calcium given intravenously is also definitely beneficial.

Positive skin reactions with foods or inhalants are rarely elicited in chronic urticaria unless the urticaria is accompanied by mucous membrane involvement. Drugs or focal infections are the commonest causes of chronic urticaria. Among the foci of infection, abscessed teeth and toxins from the intestinal tract are the commonest offenders.

Among the antiallergic drugs, ephedrine orally in a dosage of $\frac{3}{8}$ to $\frac{3}{4}$ grain every 4 to 8 hours frequently gives symptomatic relief.

Propadrine hydrochloride, as stated by Black, seems superior to ephedrine in relieving urticaria or angioneurotic edema. The dose of propadrine is $\frac{3}{8}$ to $\frac{3}{4}$ grain in capsule form every 3 to 6 hours as needed.

Benadryl and pyribenzamine are most effective in relieving the itching accompanying hives.

The use of nicotinic acid, 20 or 25 mg , with calcium lactate, 5 grains, 3 times daily with meals, as recommended by Chambers and Bernton, is harmless and worthy of trial.

Black highly recommends synthetic vitamin K (menadione), 2 mg. 3 times daily before meals, in the treatment of urticaria, but I have seen no startling results from its use.

Dilute hydrochloric acid, 15 to 60 minims in a glassful of water with each meal, may completely cure urticaria, particularly when there is achlorhydria or hypochlorhydria.

Autogenous blood injections are worthy of trial in stubborn urticaria and occasionally bring relief when all other measures fail.

NEW DRUGS

It is time now for a conservative appraisal of the newer antiallergic preparations, benadryl and pyribenzamine.

Benadryl. The most encouraging results with benadryl have been obtained in the symptomatic relief of urticaria and hay fever. Results in bronchial asthma are quite disappointing, and an occasional patient reports aggravation of asthma from benadryl. However, I have seen gratifying relief from benadryl in infants and young children suffering with asthmatic bronchitis.

The adult dose of benadryl is 25 to 100 mg. in capsule form, and the dose for children is 1 to 3 drams of an elixir containing 10.0 mg. of benadryl to the dram. Benadryl is best taken after meals and at bedtime.

Most patients who take benadryl experience unpleasant side effects such as drowsiness, weakness, dizziness, mental confusion, nausea, dryness of the mouth and throat, nervousness, and general malaise. In view of these unpleasant side effects, it is advisable to restrict the drug to the minimum effective dose. Sleepiness, one of the most frequent symptoms complained of, can be offset by ephedrine, amphetamine, or caffeine in the form of strong coffee.

Pyribenzamine. Pyribenzamine is similar in its effects to benadryl, but is apparently less toxic, although the side effects are of the same nature. The adult dose of pyribenzamine is 25 to 100 mg. in tablet form, and the dose for children is 25 to 50 mg. Because of the side effects, pyribenzamine like benadryl is best taken after meals and on retiring.

Benadryl and pyribenzamine are so-called antihistaminic drugs in that they are supposed to neutralize the histamine-like substance that is released from the shock organs during allergic reactions. Benadryl and pyribenzamine are valuable additions to our armamentarium, but do not constitute the magic key to the allergy problem. They will not obviate the necessity of avoiding the offending substances, nor do they supplant the specific desensitizing injections.

1801 Eye Street, N.W.

President's Page

OUR CIVIC RESPONSIBILITIES

It appears that the editorial, "Psychopathic Division of Gallinger Hospital," which appeared in the October issue of the ANNALS, has served a very useful purpose. It was instrumental in focusing the attention of District officials, Congress, and the public on the sad situation which exists in the psychiatric service at Gallinger. As an example of the importance which is placed on the opinions of our Society or its individual members, this is impressive enough. More important, it is indicative of the fact that with prestige goes civic responsibility.

Because of its nature and the special qualifications of its members, our organization should always take the lead in matters pertaining to health and welfare in the community. Our members, many of whom serve in official capacities with civic organizations as representatives of the Society, are in the best possible position to observe the conditions existing in various groups and institutions. Such contacts should be used to establish the Medical Society in its position of leadership in matters pertaining to health and welfare.

It is not my purpose to encourage criticism for its own sake. We must always be prepared to offer help and advice. However, we should not shrink from speaking our minds where an intolerable situation exists.

In closing, I wish to extend to each of you my best wishes for a joyous Christmas season and a happy and prosperous New Year.

Raymond T. Holden

Editorials

CHRISTMAS SENTIMENT

The envelope bore the return address of a Home for the Aged and inside was a check for three dollars and a letter to the Society requesting membership for one year.

In these days of carping criticism on all fronts, foreign and domestic—and medicine has come in for its full share—it was a bit reassuring to open the day's mail and find that someone, removed from the stress of earning a living, someone who had time to ponder on values other than economic ones, had given thoughtful consideration to the advisability of becoming a member of the District Medical Society and decided that, yes, it was worth a trial—for a year, maybe, even though it did cost three dollars.

Some of our doctors weigh carefully (and well they might) the benefits to be gained from membership in the Society as compared to its cost. What this little old lady had in mind by way of benefits, we shall never know. Nor how she estimated the membership dues. But she made no inquiry of benefits to be received, did not even ask for a membership card. She sent her money in good faith that the benefits would be bestowed upon her.

Which brings a satisfactory Christmas message for all of us in these lingering days of 1947—a little more faith in benefits to be bestowed plus a little more doing that benefits will be bestowed. It doesn't take so much faith or so much doing in these United States to believe in benefits—not much effort to make sure that Santa will arrive as scheduled on Christmas Eve. In other countries it may be a bit harder to have faith in benefits to come—if not this Christmas, maybe next, or surely some Christmas in the bleak years ahead.

Which brings us to the second part of the Christmas message—a little more doing that benefits will be bestowed. In our usual efficient American way, we have lumped our doing for the less fortunate in this land by making one large contribution to the Community Chest, and then in December for good measure we paste a hundred or two TB seals on our envelopes and packages. It takes a little more effort and a little more doing to provide for the less fortunate in other lands: sending ten-dollar checks to CARE, Inc. for food packages, depositing discarded woolen garments at church collection centers, contributing to China Relief, American Aid to France, British Relief, Philippine War Relief, and assisting American Relief for Czechoslovakia by buying the Christmas cards made at Jedlicka Institute in Prague by handless children of that unfortunate country. These individual contributions when multiplied by thousands will go far toward bringing a modicum of joy into the lives of millions of little people who are doing their bit day by day, not asking for much, but just having faith that somehow, sometime just a few benefits will come their way.

I wish we hadn't written such a formal reply to the little old lady; that we hadn't told her that there must be a misunderstanding because our Society was not open to nonprofessional people. Instead I rather wish that we had thanked her for the compliment of wanting to be one of us. I wish we had told her that membership in our Society entails certain responsibilities and duties which she, in her declining years, did not have the strength to assume and therefore we were returning her check. I wish we had reminded her that membership in that larger Human Society, of which we are all members and which requires no dues as such, asks only the contribution each of us is capable of making; that over the years we felt sure her own contribution must have been considerable; that since she was young enough to develop new interests, as evidenced by her letter to us, we felt she still had more to contribute herself than she could ever receive in benefits by joining our organization or any other.

Around Christmas time one does grow sentimental. But what a staggering total of man-, woman- and child-hours of happiness would be lost to the world if we didn't.

A. L. E.

PLANS FOR ERADICATION OF TUBERCULOSIS*

Every citizen of the District of Columbia who has the welfare of this great city at heart rejoices that it is to have the advantage of a city-wide chest X-ray survey. This survey will reveal the extent of our tuberculosis problem. That there is a problem no one denies. Some have said that of all cities of its size Washington has next to the highest death rate from tuberculosis, others that it is fifth or seventh on the list. Just what its place is in this list is not important. If its rate is anywhere near the highest, there is cause for concern on the part of all of us. When, however, we compare Washington's death rates with those of the country as a whole, we must without question hang our heads in shame. In 1946 United States provisional figures gave the rate of tuberculosis deaths per 100,000 population as 35.9. In Washington the rate was 62.3. Thoughtful citizens, and these include doctors, want every effort expended to bring this city at least within hailing distance of the country's average. The proposed Chest X-ray Survey, sponsored by the District of Columbia Department of Health, the District of Columbia Tuberculosis Association, and the United States Public Health Service, will be an important effort toward that end.

Forty years ago a program for the control of tuberculosis was laid down by a great leader in public health. That program is still unchallenged: (1) find the case; (2) treat it; (3) isolate the patient; (4) rehabilitate him; (5) keep the family together. This program was reiterated by Dr. Herman E. Hilleboe when he organized the Tuberculosis Division of the United States Public Health Service. The Washington Chest X-ray Survey, which begins January 12, makes the first step of that program an actuality.

For 40 years we have been trying to find cases, each successive year or decade bringing improved technics in the procedure. However, in the past, efforts have been directed to single individuals, small groups, and groups considered especially critical. Only within the last year or two have attempts been made to locate in an entire city all cases at one time. Washington is fortunate to be the first city with a population of over 500,000 to undertake this program.

Our goal is 600,000 X-rays by June 15. This means 6,000 persons a day, 30,000 a week, for 20 weeks. That's a lot of people! To secure the coöperation of so many individuals is a job of tremendous proportions. It calls for intensive community organization to reach all segments of our city's population. Participation by members of large groups is being planned for by their own leaders working in committees: a business committee, a District Government committee, a schools and colleges committee, church, labor, embassies committees, each in turn broken down to reach the smaller groups in its classification.

Not the least of the large committees is the Committee on Neighborhood Organization. To reach residents in each neighborhood, the city has been divided according to Selective Services districts, 26 in all. Each district will have its own committee, the function of which will be to inform every resident about the Survey and arouse his interest to the point of active participation in the Survey. Organizations already existing in the several districts, such as Parent-Teacher Associations, will be urged to take on the work of making the Survey a success. Intensive educational programs are planned in each district just prior to the time an X-ray unit is placed in that district. Every effort is to be made to see that every family in the area will know why an X-ray is important to them, and when and where the unit is to be in their neighborhood. With a continuation of the citizen interest already making itself evident, the Survey ought to attain its goal of 600,000.

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* This is the twenty-first in a series of guest editorials by distinguished physicians and laymen.

Attainment of the goal, however, does not mean attainment of tuberculosis control in the District. It does mean that we will know the size of the problem which confronts the city and its residents. It means the citizens of the Distict will be aware of tuberculosis as a public health problem as never before. It means also that we can begin to lay plans to eradicate tuberculosis from our city. Some states have already set the approximate date when tuberculosis will be a minor problem in their areas. With the Survey findings in hand, Washington will be able to estimate more truly the size of the job ahead and see the day when here too tuberculosis can be as rare as typhoid.

William E. Leahy
Chairman, Washington Chest X-ray Survey Committee

THE CORPORATE PRACTICE OF MEDICINE

Many physicians have expressed interest in the problem of whether or not corporations may be formed for the purpose of furnishing medical services. As the members of the Medical Society know, certain aspects of this question were involved in the anti-trust prosecution brought by the United States against the American Medical Association and the Medical Society of the District of Columbia.

Over the years a great number of decisions have arisen in the Courts concerning the problem of the corporate practice of medicine or law. These decisions generally held that where a corporation hired or employed a doctor or lawyer on a salary basis to render medical or legal services for members or customers, or to any person or party other than the corporate entity itself, the corporation was illegally practicing medicine or law.

The fact that the corporation might be formed along coöperative or association lines, with members or subscribers, was considered by many Courts to be unimportant, and such corporations, when they likewise employed doctors or lawyers on a salary basis to render medical or legal services to the corporation's members or subscribers, were illegally engaged in the practice of medicine or law.

Group Health Association, Inc. was formed under the provisions of the District of Columbia Code providing for the organization of non-profit and mutual improvement corporations. While Group Health Association employed doctors to render its member-subscribers medical care, our Court of Appeals held that the corporation was not illegally engaged in the practice of medicine, on the theory that it did not function in a manner which interfered with the doctor's loyalty to his patient. This aspect of the Court of Appeals decision has been difficult for lawyers to understand, as the Court stated in the course of its opinion that the practice of medicine in the District of Columbia can be subject to neither "commercialization nor exploitation." The Court also said that the proper doctor and patient relationship must be preserved and that the plan of the corporation must not interfere with the doctor's loyalty to his patient or commercialize the practice in any way contrary to the best interests of the patient or practice or to subject the physician to the corporation's control (United States v. American Medical Association, et al, 72 App. D.C. 12, 110 F. (2d) 703).

It seems to many lawyers that the interjection of the corporation into the practice of the learned professions, where the corporation employs the professional man and itself receives the fee of the patient or client for the services rendered, necessarily commercializes the practice of medicine or law and places the corporate entity between the professional man and his patient or client.

In contemplation of law, a corporation is a legal entity, that is, an artificial person. As such, it is thought that all attorneys will concede that this corporate person cannot qualify to practice medicine itself, as it cannot take the examinations required by the laws of all states and the District of Columbia controlling the practice of medicine, and, of course, cannot meet the personal qualifications as to education and training prescribed in such laws. Notwithstanding this situation, in the District of Columbia we must, however, remember that our Court of Appeals in the American Medical Association case has approved to some extent corporate practice of medicine organized along coöperative lines without the issuance of shares of stock and where the avowed object of the corporation is to mutually assist its members.

Where the corporation involved is organized along ordinary business lines with a profit object and with provisions for the issuance of shares of stock, it would seem, when such a corporation employs a physician or an attorney to render services, that it engages illegally in the practice of medicine or law. Thus, in Silver v. Lansburgh Bros., 72 App. D. C. 77, 111 F. (2d) 518, our Court of Appeals approved to some extent the language which it used in the American Medical Association case and then held:

> "A corporation engages unlawfully in the practice of medicine when it employs licensed physicians to treat patients, itself receives the fee, and the profit object is its main purpose, the arrangement being such as to divide the physician's loyalty and destroy the well recognized confidential relation of doctor and patient."

The basic reason behind this statement of the Court of Appeals is that physicians and attorneys render to their patients and clients a pure personal service, dependent for success upon a confidential relationship involving complete disclosures and the highest confidence. In such situations it follows that the necessary disclosures required cannot exist where a profit-seeking corporation attempts to render such service and receive the profit therefor. This fundamental principle involved in the question under discussion is well stated by the Court of Appeals in the Silver case, wherein the Court said:

> "But we prefer to rest our view upon the broader distinction arising out of the traditional relationship between physician and patient and attorney and client, a relationship which does not exist in the practice of optometry. The professional service required of the former, of its very nature, creates a relationship of trust and confidence. Both in the case of the physician and the lawyer, the person seeking his services must break down the barriers of reserve which otherwise serve to protect him and deliberately reveal to his professional adviser secrets of physical or mental disability or secrets of business of the most intimate nature. These necessary disclosures create the personal relationship which cannot exist between patient or client and a profit-seeking corporation. The universal recognition of this immediate, unbroken, and confidential association between doctor and lawyer and those who engage their services early created and still justifies the rule that their allegiance must be wholeheartedly to the patient or the client, and not to another."

In closing, it might be well to point out that while many occupations are now called "professions," such as the employment of accountants, architects or engineers, the law generally classifies the learned professions to be medicine, law and theology, and that cases dealing with other so-called professions are not applicable to the corporate practice of law, medicine or theology, because they do not involve the traditional relationship involving trust and confidence that exists in the true learned professions.

It will be a sad day when Courts permit the learned professions to be commercialized and exploited by corporate entities. No corporate entity, no matter how well formed and organized, can ever replace, without loss to the public, the personal services rendered by the physician to his patient under circumstances of confidence, trust and true allegiance that wholeheartedly exist between the physician and the patient.

Warren E. Magee
Legal Counsel to the Medical Society of the District of Columbia

PREMARITAL MEDICAL SERVICE

Within recent years the most casual reader of newspapers and popular magazines must have sensed a rapid increase in public concern about the realistic preparation of young people for marriage. Several factors are involved in this trend. Most spectacular among them is a sharp rise in our national divorce rate. Another element has been the many contributions of psychiatry and social science in demonstrating the genetic relationship of unhappy family life to mental disorder and crime. A general weakening of ancient sex tabus has made possible more open and honest discussion of the sex factors in marriage. The recent appearance of a worthy and steadily improving scientific literature dealing with every aspect of family life has given to writers of news and feature stories a great deal of material which they have put before the public.

We in the medical profession have reason to take pride in our contributions both to the understanding of marriage problems and to their solution. It has been our pioneer psychiatrists, gynecologists, urologists and pediatricians who have done the most important scientific work in the marriage field. It is principally their work that forms the basis of our improving standards for aiding young people to achieve successful marriage. We should, however, acknowledge the fact that our profession has not, as a whole, been distinguished in promoting public interest in medically directed preparation for marriage. Much of the leadership in this regard has been assumed by nonmedical professional people in the fields of religion and education.

It is significant that all of the great religious groups in the United States, Protestant, Catholic and Jewish, are now officially and actively concerned with the realistic preparation of their younger generation for marriage and that they accept medical service as a part of such preparation. Several years ago the Federal Council of Churches of Christ in America (Protestant) established a Commission on Marriage and the Home. This Commission has approved premarital medical service as a part of its recommended preparation of young people for marriage. The National Catholic Welfare Conference maintains a Family Life Bureau which indorses premarital service to those of the Catholic religion. The Jewish faith supports premarital service through its Institute on Marriage and the Family.

The policies of these leading religious groups have surely relieved the medical profession of any strained caution about the religious-moral acceptability of a high type of premarital medical service. The fact is that the great religious groups now expect of the medical profession active coöperation in the preparation of their younger members for marriage. There are still some religious doctrinal restrictions about the scope of premarital medical service, but the restrictions have been remarkably liberalized within the past two decades.

During recent months members of our Society have appeared as speakers on Marriage Institute programs presented in Washington by all three of the larger religious groups.

In addition to the religious groups there are other large national organizations that have an active interest in promoting premarital medical service. One of these is the Planned Parenthood Federation of America, which maintains several hundred clinics operated by its State Chapters. All these clinics are staffed by physicians. Other important national organizations that support premarital medical service are the National Council on Family Relations, the Family Welfare Association of America, the National Committee for Mental Hygiene, the American Social Hygiene Association, and the American Association of Marriage Counselors.

An increasing number of our colleges and universities are giving courses on marriage and the family. These courses invariably stress premarital medical service as highly desirable.

The above-mentioned references to organized interest in premarital medical service make it apparent that this kind of service has passed the tentative stage and has become a widely accepted obligation of the medical profession.

Here in Washington we do not yet have a law requiring a medical certificate as a prerequisite to obtaining a marriage license. However, a large majority of our states do have such laws. Because many of our Washington young people return to their family homes in the various states to be married, our physicians are often called upon to conduct the required state medical examination. We regret a lack of uniformity among the state laws but have seen that they are a potent force in controlling venereal disease and offer the interested physician an opportunity to extend complete premarital medical service to many who otherwise would not enjoy its benefits.

The major share of responsibility for providing adequate premarital medical service necessarily falls upon our general practitioners. Up to this time their medical school training has not been adequate for the task, and the doctor who would qualify himself must make a considerable effort through special study. The time seems near when he may find help in well organized postgraduate courses at leading medical centers, although no such courses are known to exist at present.

It is suggested as a medical responsibility that in the years ahead physicians should undertake a more active role in coöperating with religious, educational and civic groups toward gaining universal public acceptance of premarital medical service. There lies in this ideal more than just the obvious worth of the service. When a young couple receive a good routine premarital service from a physician, they are disposed to depend upon qualified medical aid as the need arises during married life. This can be of great value in keeping them out of the hands of the unqualified persons who are still allowed to practice medicine under licensing laws that afford the public inadequate protection.

It may be predicted with confidence that, when the medical profession becomes fully aware of the possibilities of high quality premarital medical service and provides adequate professional training in the field, an important public service will have been accomplished. It should be added, also, that through this achievement greater warmth will come to our relations with those whom we serve.

Walter R. Stokes, M.D.

MEETINGS

Wednesday, January 14

Business Session

Speakers and subjects for the scientific program following a brief business session will be announced later.

Wednesday, January 28

The Section on Gastroenterology will sponsor the program. Speakers and subjects to be announced.

In and Out of Focus

BY THE OBSERVER

Our Membership

The growth of our Medical Society since the close of the War has been phenomenal. The question now in the minds of the Society's officers is—how long will it continue?

Membership on November 1, 1947 was 1,487—1,155 Active, 79 Life, 241 Associate, and 12 Honorary members. There are some 98 applications pending, most of which will be voted upon favorably by the Executive Board at its December or January meeting. This will bring the total membership to well over 1,500.

Applications are still being received. Hardly a day passes that the mail does not bring one or more. It would not be too astonishing, therefore, if the total membership reaches 1,700 or 1,800 before the close of 1948. Whether this figure can be maintained is another question. No one knows the saturation point. The study of physicians in the Washington metropolitan area, which was published in the October issue of the MEDICAL ANNALS, showed that the ratio of physicians to population is practically what it was in 1941. Whether the ratio can be increased, and the physicians still be in sufficient demand to warrant their remaining in Washington, only time will tell.

In view of this tremendous increase, the Executive Board has requested the Membership Committee to proceed with plans for an orientation program similar to that conducted by the Los Angeles County Medical Association; also to arrange social get-togethers which would bring about closer acquaintanceship of the membership. When one considers that nearly half of the membership is comparatively new, these projects will serve a most useful purpose.

Despite efforts to keep them informed, too few members are familiar with the services available to them through the Society, or what it is doing for the medical profession. The MEDICAL ANNALS, bulletins and communications have been increasingly effective mediums, but more is required, especially where applicants (including those who have not completed their probationary year) are concerned. What is now proposed is that they be required to attend a series of lectures on medical organization, medical ethics, medical malpractice, and medical economics. Attendance at these lectures would be mandatory. At their conclusion, applicants would be examined to ascertain their understanding of the subjects discussed. Reports from Los Angeles and elsewhere indicate that these lectures have been welcomed by applicants, who have found them enjoyable as well as enlightening.

It is hoped that interns and residents can be included in this group. The Membership Committee has proposed that a separate membership classification be set up for them with very nominal dues. This will require an amendment to the Society's By-laws. The Executive Board has given its approval, and it is expected that the Society will consent. Undoubtedly many residents and interns will find it desirable to affiliate with the Society.

There is no need to elaborate on the value of social functions where the membership is concerned. Faternization in an atmosphere of good will inevitably results in better understanding. Suspicion and ill will are swept away when physicians have an opportunity to know each other personally.

Mention should be made of the quality of the Society's new members. They are generally excellently trained and of the very highest type. Having met each one of them personally, your Observer does not hesitate to predict that, largely due to their superior qualities, the

Nation's Capital will take its rightful place as a great medical center.

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Our Mentally Ill Public attention has recently been focused on the care of the mentally ill at Gallinger Hospital. Largely responsible was an editorial on the subject which appeared in the October number of the MEDICAL ANNALS, entitled "Psychopathic Division of Gallinger Hospital," by Dr. Isadore Rodis. This was promptly "spotted" by Washington newspapers. The *Evening Star* ran a series of articles entitled "A Disgrace to Washington." Disclosures undoubtedly shocked many complacent District residents, for it was revealed that the psychiatric department at Gallinger was sadly lacking in personnel and equipment, making it impossible to provide mental patients with adequate care.

However, there was really nothing new about the facts presented. Inadequate facilities for the care of mental patients at Gallinger had come to public notice before. Urgent appeals for funds had been made by the District Health Officer, only to be pigeon-holed. When the flurry of publicity attendant upon these disclosures had subsided, the matter was forgotten or was at least quiescent. It is to be hoped that this time, the public, the press and the medical profession will not forget until something has been done to improve the psychiatric service at Gallinger.

It might be pointed out that the situation at Gallinger is unfortunately not unique. In fact, conditions are no worse and perhaps better than in many state institutions throughout the country. In some of these institutions, they are so bad as to be disgraceful. Undoubtedly public officials must accept a large share of responsibility for this situation. In the final analysis, however, the responsibility lies with the people themselves. If they were not indifferent to the welfare of the mentally ill, conditions would not be what they are.

Dr. George S. Stevenson, Medical Director of the National Committee for Mental Hygiene, recently wrote an article for the *New York Times Magazine*, entitled "Needed: A Plan for the Mentally Ill," which every citizen could profitably read. Directing his attention to mental institutions, Dr. Stevenson says they are crowded far beyond their capacity; there are not enough qualified psychiatrists, with the result that those who are on the staffs have more than they can handle adequately; competent nurses and attendants are unobtainable by large mental hospitals because of poor employment and living conditions; and finally, that mental institutions have not kept up with the advances in psychiatry. "Our public psychiatric system," he declares, "operates in isolation and superficially, much as it did forty years ago."

But Dr. Stevenson believes that adequate institutional care is only part of the solution. He says that we have "millions who are not ill enough to require hospitalization, but who still need help." Therefore he urges that every effort be made to bring psychiatry closer to the community and nearer to the centers of research and learning. He suggests the desirability of the hospital ward becoming "an adjunct service."

> "Instead of having hospitals as the core of our psychiatric care," he continues, "I suggest we look for administrative leadership to a district, municipal, county or regional director of psychiatry. He would have the responsibility for:
>
> "(1) The care and treatment of protracted, severe psychiatric cases needing hospitalization, the type now occupying most of the beds of our mental hospitals.
>
> "(2) The care and training of protracted cases of mental deficiency not returnable to the community who are now in an institution for mental deficiency or awaiting admission because the institution is too small or holds cases that should be in the community.
>
> "(3) The care and treatment of the legal offender whose offense is a symptom of psychiatric disorder. In this, public psychiatry would coöperate with public safety.
>
> "(4) The care of acute psychiatric cases needing hospitalization for a short period. This would be in the

local general or special hospitals or in state hospitals if conveniently situated.

"(5) The care and treatment of the psychoneurotic patient. This is to a limited degree a matter of hospitalization, and then usually in a general hospital. To a very extensive degree it is a matter of outpatient service.

"(6) The care of behavior problems, especially those of children. In this, public psychiatry would coöperate with public health, public education and public welfare.

"(7) Consultation to teachers, social workers, courts, public health nurses, ministers, general-practice doctors and others in the community who are dealing with people in trouble, so that they may more adequately deal with the lesser psychiatric problems involved in their work and know how and when to refer the more severe cases to a psychiatric clinic.

"(8) The ferreting out and correction of defects in the community, such as inadequate recreational facilities and industrial hazards, which contribute to emotional disorders and mental breakdown."

☆

"Health Is a Security Problem" One does not think of the Army as being directly concerned with the health of the civilian population. This is usually considered within the province of the United States Public Health Service. But apparently the Army has other ideas, particularly when the Administration needs a hand with its health program.

Upon returning home one evening a few weeks ago, your Observer's attention was called to material pertaining to health which had been received from the Women's Interests Unit, Public Information Division, Department of the Army. In examining it, he was frankly impressed by the method adopted by the Army to gain the support of mothers and wives of ex-service men for its views. He was particularly interested because the communication and enclosed statement related to health and national security, and had been prepared for use by women's clubs.

As was to be expected, the statistics presented emphasized that rejections for military service in World War II were largely due to preventable physical defects. This, it was stated, constitutes a direct challenge to the Nation. In fact, the health of every individual is directly related to the national welfare.

"At present the number of sick and 'ailing' is always large enough to be a serious drain on the national economy," the statement continued. "Persons afflicted with nervous and mental disorders, for example, are but one part of the total who are 'usually' ill, but they are of grave national concern. In 1943, nervous and mental patients in United States hospitals numbered 499,000, about equal to the combined populations of Nevada and Wyoming. Many thousand others, though not hospitalized, are incapable of steady work.

"The ability of industry to produce at highest efficiency depends upon having full strength at work. Only healthy people can work well. Because they work well, they produce and earn. Because they earn they have buying power, they stimulate industry to provide their wants. Providing their wants creates jobs. Good health helps to produce national wealth.

"Reversing the picture, sick and unhealthy people cannot work effectively. They do not produce as much per capita as healthy people do. This restricts earning power, therefore they cannot consume as much unless someone else pays for it. As a result they frequently become a drain upon the public purse. Taxes must be paid to support medical facilities for them, to check the spread of disease, and for other reasons of public safety.

"Poor health becomes a drain upon national wealth; but good health and national wealth contribute to national security. The health of every individual is important to national security. Health is a security problem."

Brigadier General James S. Simmons, Chief of the Preventive Medicine Service of the Office of the Surgeon General, was quoted as saying, "Every county in the United States must be provided with efficient health services. None of the people of this Nation should be allowed to sicken or die with preventable diseases. The physical and mental health levels of the country must be raised to a point which will insure the fullest possible national vigor."

In the course of the statement, many phases of health came in for more or less detailed consideration. Included were geriatrics, automobile accidents, and scientific research.

Your Observer does not object to the conclusions drawn therefrom. As a matter of fact, he would go along with the Department in regard to most of them. What does intrigue him is why this material should be distributed by the Army. Perhaps the explanation lies in veiled suggestions favoring a tax-supported system of medical care and the urgent need for a more comprehensive health program. After all the War Department heads are on President Truman's team.

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Educational Fund for Physicians' Children

From time to time in the past few years, your Observer has discussed with committees of the Society the advisability of establishing a benevolent fund for physicians. The purpose of such a fund would be to provide assistance to participating physicians in event of illness or financial distress.

This proposal is still in the discussion stage. Some weeks ago it was again presented to the Membership Committee of the Society for its consideration. On that occasion your Observer reported that only a very few medical societies had undertaken such a project. One, which he investigated some six years ago, is sponsored by Philadelphia physicians. He cannot now recall the details of this undertaking, but he intends to make further inquiry in the near future.

What revived your Observer's interest in this matter was an address by Dr. Elmer Hess, President of the Medical Society of the State of Pennsylvania. Presidential addresses do not often provide exciting reading, nor do they frequently contain specific proposals. The speaker is usually content to take a broad view of the medical scene. But Dr. Hess is not that kind of a president. He is a dynamic, outspoken, and aggressive medical leader. No diplomat, he says just what he thinks. There is never any doubt as to where he stands, which undoubtedly accounts in part at least for the high regard in which he is held by his colleagues. Knowing these things about Dr. Hess, your Observer read with more than ordinary interest an address given by him on the occasion of his induction as president, which appeared in the October issue of the *Pennsylvania Medical Journal.*

Early in his address Dr. Hess stated unequivocally, "I want the doctors and their wives to raise a half million dollars for an educational fund." Enlarging upon this rather ambitious proposal, he said, "For years I have been interested in our Medical Benevolence Fund, which provides one of the most important activities for the Woman's Auxiliary. Stimulated primarily by my wife's early interest, we have together become constant contributors to it. I have seen its benefits in action; however, the fund is limited in its use to the relief of pecuniary distress. I want to see the Medical Society really do something more for its members or the members of their families. We are always doing something for others—let's now do something for our own.

"Most physicians marry comparatively late in life. Too often physicians die or are incapacitated while their children are in secondary school or college. Most of the families are not poverty-stricken nor paupers, but the physician, if crippled, may not be able to have his most cherished possession, his children, continue with a higher education. Again, the widow and children of a deceased physician may live from his estate but without funds for the continuation of the children's education. This half million dollars or more could be used to help such families of physicians to continue that education. This is security, not charity. The fund raised, the proceeds should be used freely for the purposes outlined, controlled by a Board of Directors consisting of three from the Medical Society and three from the Woman's Auxiliary, plus two advisers experienced in finance and management. Distressing delay would thus be avoided and financial assistance with sound advice would be promptly available when illness or death interrupts the income of the physician-head of a family. The county society and auxiliary will know the situation and could act as the contacting agent with the central committee to arrange for the help to continue the children's education. Oftentimes, during the period after the doctor's death, while his affairs are being settled, his widow may be at her wit's end wondering how to keep a son or daughter in college or medical

> school. The fund could help her during such a period and she could repay the fund if her circumstances permit. If not, then the fund could be used to help the deceased or crippled physician's children complete their education.
>
> "Do you see what I mean? With such a fund available, younger members of our society would feel that their children would be educated no matter what happened to them. Older members would have a feeling of satisfaction when they realized that their confreres would step in and help their children finish their education if needed. A half million dollars is a lot of money, isn't it? The answer is yes. Where can we get it? The answer is easy. Our society has 10,000 or more active members. Ten dollars a year from each doctor for five years, a total of $50 apiece, will give us actually a half million dollars. It should not be hard to raise. The Woman's Auxiliary and the county societies could raise it easily. How? Divide the doctors into groups of 20, have a man or woman, or both, assigned to make the collections from the other 19 in their group, and have the counties send the money into the state organization. Let the Central Committee invest the funds under proper supervision and use the income according to rules and regulations set up by the committee. I am sure that such a committee would be fair and faithful to the rest. Surely we can afford to do this for ourselves. Will you help?"

Your Observer likes this proposal, difficult though it would seem of accomplishment. He suspects that obstacles in the path of this project will not trouble Dr. Hess too much. They will undoubtedly prove to be the incentive needed to see it through.

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Fear of State Medicine

According to Dr. Clarence C. Little, Director of the Jackson Memorial Laboratories at Bar Harbor, Maine, one of the obstacles to progress in cancer control is the medical profession's fear of state medicine. He says it "has long existed in the minds of so many of the organized medical profession. It has at times reached hysterical proportions and seems generally to be emotional rather than logical or intelligent."

> "In the cancer program," Dr. Little observes, "one finds its chief impact in the relations between the profession and the clinics for the detection, diagnosis and treatment of cancer. Informed and alert members of the profession have by now largely overcome this feeling. There remain, however, a considerable number of backward members of the profession who are motivated selfishly rather than by an honest attempt to understand the disease of cancer and to realize how widespread must be public participation in the attack on it."

Dr. Little ascribes the uneasiness of the profession with respect to the cancer program to "emotional reactions to the many years of the Roosevelt administration," adding that it has "created in this country a large body of important citizens who still transfer to the Federal Government the same feeling that they have toward the various developments of the New Deal."

> "It is not my purpose," he declared, "to argue the merits or defects of the theory of the New Deal, but I do wish to emphasize the stupidity and essential immorality of allowing political feelings to obscure or blind our vision concerning cancer control.
>
> "Government effort in the attack on cancer has come to stay. In my opinion the governmental agencies engaged in cancer research and cancer education have done an outstanding job in the face of irrational opposition and during a period when all the factors, economically and socially, were unfavorable."

Calling upon medical organizations to act constructively for the purpose of improving facilities for cancer detection, diagnosis and treatment, he decries "jealousies and prejudices to weaken or divert their humanitarian function." "There is ample room for all the profession in the program of cancer control," he says, "and it is not possible for any limited number of hospitals or clinics to monopolize positions of authority in the fight against this disease. Obviously it is impossible for all hospitals and clinics to progress at an equal rate and differences in efficiency will probably always exist.

"This does not mean that the weaker institutions should be condemned or criticized but rather that they should be encouraged and strengthened so that they may as soon as possible take a more constructive part in the program."

It is regrettable that Dr. Little felt it necessary to be so outspokenly critical of the profession. Whatever bases there exist for his criticism, it fortunately does not apply to the physicians of Washington. The profession here has actively and energetically supported the cancer program of the District Division of the American Cancer Society and the District Health Department. Some months ago, the Medical Society's Committee on Cancer Control developed standards for the conduct of cancer detection clinics. Whole-hearted coöperation was given by the Society to the Health Department's survey of cancer cases in the District of Columbia. By word and deed it has made it clear that it proposes to do its full share to combat the most dreaded disease of our times.

★

"Starchy and Persnickety 'Ethics'"

There is no denying the fact that *Time*, the weekly newsmagazine, even when it is inaccurate, is highly interesting. Like many longtime readers of *Time*, your Observer delights in its colorful reporting. However, at times he finds its flippancy irritating. An example of the latter is a reference to organized medicine in an article appearing in the November 17, 1947 issue, entitled "How Am I, Doctor?" Described—and very well too—are health broadcasts of Dr. Charles Hill, Secretary of the British Medical Association. Commenting on the fact that Dr. Hill's broadcasts are anonymous, *Time* parenthetically ascribes this to "organized medicine's starchy and persnickety 'ethics'."

This, of course, is not the first time that ethics or rules guiding the conduct of British and American physicians have been referred to slightingly. The impression is frequently given that ethics are for the protection of physicians, professionally and financially. Nothing could be further from the truth. If the critics of the medical profession wished to be fair, they would interpret medical ethics in the spirit in which they were written. Of course, they are not perfect, nor is any such claim made. As a matter of fact, they are constantly under revision to meet changing social conditions.

With all their faults, a vast majority of physicians adhere to higher ideals than the members of any other profession, with the possible exception of the clergy. This is due in no small measure to these "starchy and persnickety 'ethics'." (And what does *Time* mean by placing ethics in quotes! Obviously, no compliment was intended.)

Returning to Dr. Hill's broadcasts, your Observer is not too familiar with the rules of conduct prescribed by the British Medical Association, but the Principles of Medical Ethics of the American Medical Association, Chapter III, Section 4, states, "Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not per se improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

"It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients."

It should be obvious, even to *Time*'s reporter, that if physicians generally went on the air or wrote about themselves in the newspapers without any restrictions, the public would suffer. People would have no way of knowing whether or not the claims of the individual practitioners were justified. The field would be wide open for all sorts of chicanery and charlatanism.

Members of the District Medical Society are, of course, governed by the Principles of Medical Ethics. They are also guided by general recommendations relating to publicity adopted by the Society on March 6, 1940. These approve the use of a physician's name and his official connection with a medical society, hospital staff, medical school faculty, organization or government department. Objections are raised to physicians' names being used where the type of practice in which they are engaged is mentioned.

There are undoubtedly sound reasons for criticism of the Principles of Medical Ethics or other rules promulgated by medical societies, but in your Observer's opinion, there are many more reasons for praise.

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A Check on Charity

No physician is doing justice to his patient who does not keep him under observation until discharged; the same principle applies to many other professional people rendering personal service. For example, a follow-up on cases assigned to social welfare workers is an essential procedure. These workers would not only be derelict in their duties, but incompetent, if they failed in this respect. However, no one can charge them with lack of zeal in following up on their cases. In fact, the complaint usually is that they are overzealous, and lacking in good judgment. Undoubtedly this charge might be made against other professional groups, but, according to the *New York State Journal of Medicine*, it applies with special force to social welfare workers. That is the point of an editorial on charity appearing in the November 1, 1947 number of the *Journal*.

Thirty years ago, when a surgeon removed a patient's appendix, and he was fortunate enough to leave the hospital "under his own steam," the hospital recorded the fact that the patient had been "cured." "There were optimists in those days," the *Journal* says. "Nowadays, patients are followed. Relentless social workers camp upon their trails. They point out that even minus an appendix, a patient, unhappy at home, will go on to develop gastric or duodenal ulcers, mucous colitis—gracious Heavens, what won't they get?" Expressing a belief in the principle of follow-up, the *Journal* published the following letter which it received from a correspondent.

> "I live on what I am sure you would call a civilized block in New York City. It is in a neighborhood which has become fashionable in the last twenty years. Certain properties on my block have remained unchanged. One of them is a brownstone house of conventional design, whose stoop sticks out like an unblown nose in the middle of a row of stoopless, remodeled, repainted houses. The done-over houses are inhabited by sculptors, playwrights, authors, doctors, and business men, people of fairly moderate means, but, perhaps, above the average in intelligence.
>
> "The brownstone front has a blue enameled sign in front of it which says 'Hospital Street. Quiet Please.' Otherwise there is no designation on it to mark it as a hospital. For years I passed it numbers of times every day, without a thought except as to its outward ugliness. Then I found out what it was. A home for unmarried mothers. I have never seen the blinds up on the front of the house. Neighbors who live at its sides and in its rear assure me that the blinds are never up there, either. In its sepulchral interior its unfortunate inmates sing hymns.

(*Continued on page 718*)

HOBBIES

M. Pierce Rucker, M.D.

Editor, Virginia Medical Monthly

Editor's Note: The Virginia Medical Monthly is undoubtedly one of the most attractive and well edited medical journals in the South. It is therefore a pleasure to present a contribution by its able editor. Here is a common-sense prescription for enjoying life to its utmost.

It has been said that the reason Theodore Roosevelt accomplished so much in his lifetime was that he had two hobbies which he pursued with constancy and energy from his boyhood days. One hobby was the study of natural history and the other was reading. The late John A. Sampson, in his Presidential Address before the American Gynecological Society in 1923, spoke of the value of hobbies in the training of youth and especially in the preparation for a medical career. A hobby stimulates interest and develops the faculty of observation. It teaches the child to learn for himself. In later life this is called "research"; the child calls it fun. There are many secondary benefits. Collecting stamps teaches the child something of geography, the money values of foreign countries, and even something of their history. Mineralogy, botany, ornithology, ichthyology, herpetology, malacology, helminthology, entomology, paleontology and taxidermy promote healthful outdoor activity. As Sampson said, "Hobbies in the various branches of natural history furnish the child with the incentive for outdoor recreation and the clinical study of life in fields, woods and streams" and supply a reason for the study of English and of drawing to give expression to the knowledge gained. Sometimes the hobby becomes too engrossing and must be hobbled, but this is infrequent.

From the standpoint of health, hobbies are of even more importance as a man reaches maturity. This is particularly true for doctors. A successful doctor becomes so absorbed in his work that nothing short of a hobby can pull him away from it. Coronary disease causes the death of so many physicians that it is sometimes called the "doctor's disease." This is good evidence of the strain he is subjected to and of the long, arduous and irregular hours that the doctor spends at his work. The doctor should have two hobbies, one physical and the other spiritual. The one will furnish him with needed fresh air and exercise, the other will divert his mind from the cares and anxieties that are a part of his daily routine.

With advancing years and the diminution of the margin of safety of his various organs, the physical hobby should be turned out to pasture and enjoyed only in contemplation. It is then that the other hobby becomes especially useful. As our neighbor, Wingate Johnson, says, in his delightful little book, "The Years After 50," "The average individual of middle age or beyond needs recreation more than exercise." He names a number of hobbies suitable for this period: wood carving, photography, and the collecting of stamps, books, glassware, or other desirable objects, but the recreation par excellence is reading. One finds that there is so much to live for at a time of life when many are depressed with a feeling of futility. But it does not greatly matter what sort of spiritual hobby one chooses so long as it excites his interest. (Unless it does it is not a hobby.) In any case, one should exercise it often enough during his active career to have it limbered up and ready for intensive use when he reaches the age of partial or complete retirement.

CANCER PREVENTION OR DETECTION CLINICS

Calvin T. Klopp, M.D., F.A.C.S.

Director, Warwick Memorial Clinic for Cancer and Allied Diseases

In recent years, a series of cancer prevention or detection clinics have been established in several of the large cities, i.e., The Strang Cancer Prevention Clinic in New York City, The Donner Health Maintenance Cancer Prevention Clinic in Pennsylvania, and the Chicago Cancer Detection Center in Chicago. These clinics have uncovered a demand from the public for routine physical examinations of well persons for the purpose of discovering cancer in its earliest and most readily curable stage.

In December 1946 a cancer prevention clinic was sponsored in Washington, D. C. by the Ladies Aid to Garfield Memorial Hospital. This Clinic began on a trial basis and on a very limited scale in order to discover its place and need in the community. This Clinic is under medical supervision of the staff of the Warwick Cancer Clinic, which has furnished the clinic facilities for these examinations. The remainder of the volunteer aid is supplied by the staff of Garfield Hospital, and the Garfield Ladies Aid. The financial assistance is from the Ladies Aid to Garfield Hospital, the District of Columbia Division of the American Cancer Society, and the Washington Home for Foundlings through the Warwick Memorial Cancer Clinic.

As this Cancer Prevention Clinic has now been in operation for over six months, and as the American College of Surgeons has agreed to assume a supervisory role in relation to these centers and developed a standard for their guidance, it seems advisable to bring our knowledge up to date and make it readily available. The District of Columbia Division of the American Cancer Society has set aside $25,000 to help support these clinics in the District of Columbia; and the Medical Society of the District of Columbia has developed local standards to fit conditions in our area.

The Role of the American College of Surgeons in Cancer Detection (Prevention) Centers

As these detection centers were developed in the last ten years, the American Cancer Society became aware of the desirability of there being some uniform standard of guidance for those conducting such centers. The American Medical Association approved such a procedure of standardization so long as there was conformity with the policies of the local medical societies. At the invitation of the American Cancer Society, the American College of Surgeons agreed to accept a supervisory role over the detection clinics, develop a standard for guidance, and publish annually a list of centers which after personal survey were found to conform to the College standard.

The following are these minimum standards:

1. *Organization.* A specific plan for the organization and conduct of the center shall be approved by the County Medical Society before the project is made effective and the Society shall appoint a medical advisory committee for guidance of the staff. The detection center shall be conducted in a hospital approved by the American College of Surgeons or in the outpatient department of an approved medical school or under conditions permitting compliance with the other features of this standard. The medical staff shall adopt rules, regulations and policies governing the professional work of the center and shall review and analyze their clinical experience at regular intervals. In addition to the medical staff, which shall include representatives of the various branches of the medical profession, a secretary, nurse and medical social worker shall be available for the purposes of the center.

2. *Equipment.* The equipment shall be adequate for a complete physical examination.

3. *Patients.* All applicants within specified geographic limits shall be admitted except those who are already under treatment. Some detection centers may be restricted to males and others to females.

4. *Records.* There shall be maintained adequate, complete records of examinees which shall include identification data, occupation, history, physical examination with indicated laboratory examinations, summary, and disposition of such persons.

5. *Disposition of Examinees.* Persons who require further diagnostic procedures than are furnished by the center, or for whom treatment is indicated, shall be referred back to their physicians. If they have no physician, they shall be given a list of physicians, clinics, or hospitals from which choice may be made and to which the findings of the center shall be furnished. The detection center shall seek from the physician, clinic, or hospital a record of final diagnosis, treatment and follow-up. Examinees shall be encouraged to have periodic physical examinations as indicated.

6. *Fees.* A contribution of a specified sum of money toward expenses of the center shall be required of examinees who are able to pay.

ROLE OF THE DISTRICT OF COLUMBIA MEDICAL SOCIETY IN THE CANCER DETECTION (PREVENTION) CLINICS

At the request of the District of Columbia Division of the American Cancer Society, the Cancer Control Committee of the District Medical Society, under the chairmanship of Dr. Roger M. Choisser, met and drew up the necessary modifications which were required by the American College of Surgeons to meet the local needs of the District of Columbia. The following are the local modifications of the standards for these Cancer Detection units:

It was recommended by the Cancer Control Committee:

1. That the director of a cancer detection clinic be the chief of a service in a hospital or a diplomate of the board in his specialty and that all appointments to the clinic staff be made by him.
2. That the complete examination of an individual be made by one physician rather than several physicians.
3. That hospitals encourage physicians on their house staff to participate in clinic work as a part of the institution's educational program.
4. That a standard examination form be used by each cancer detection clinic.
5. That a minimum physical examination should include the following: (a) history; (b) examination of the oral cavity, pharynx, larynx, breasts, chest, abdomen, pelvis and rectum; (c) proctoscopy (on all persons over 35 years of age); (d) laboratory procedures, including chest X-ray, hemoglobin and differential blood count, urinalysis, and (optional) vaginal smear.
6. That persons needing further diagnostic procedures should be referred back to their physicians or to MEDICAL BUREAU, if they do not have physicians.
7. That the Medical Advisory Committee (Cancer Control Committee) determine from time to time whether standards in clinics are being maintained.
8. That a contribution of $10 be accepted from each examinee by clinics.
9. That persons having businesses or employment in the District of Columbia or who are residents of the District be eligible for examination. Applicants who are not in these categories will be examined at a fee to be determined by the director of the clinic.
10. That in the interest of good medical service, physicians on the staff of cancer detection clinics be appropriately compensated.
11. That each cancer detection clinic operate at least two half-days a week.

DISCUSSION

These local standards were drawn up to meet certain very specific local needs and problems which will be discussed in the order in which they were formulated by the local Cancer Control Committee.

1. *Organization.* The Medical Society of the District of Columbia had already agreed that its Cancer Control Committee was to work on this cancer detection problem, so it was logical that this same committee should serve as the District Society's Medical Advisory Committee for guidance of the staffs of the detection clinics.

As there is as yet no certifying board in oncology, and as some well trained and responsible individual must supervise each clinic, it was decided that the director of an individual clinic should be either a diplomate of his specialty board, or the chief of a service of the institution. This would allow equal recognition for those younger individuals who have spent long years in special training, and those older individuals who have received equal training by virtue of a longer period of practical experience. This director would then be responsible for choosing his staff of examiners, personally supervising and checking their work and physical findings, and educating them in the early diagnosis of cancer. The success of each clinic will rest heavily on this individual.

As one of the important functions of these clinics is the education of young physicians in the early recognition of cancer; as the final goal in early recognition should be to make each doctor's office a detection clinic; and as the family physician is in the best position to accomplish this, the Committee decided that, under careful supervision, the total examination of each subject shall be conducted by one individual and that the general practitioners and members of the house staff of the hospitals (especially those contemplating general practice) shall be the examiners. This also allows the Medical Society to anticipate being able to meet the demand for examinations. This would not be possible if examinations were done on an assembly-line basis, with examiners limited to those certified by their respective boards. It might be well to consider listing in the MEDICAL BUREAU, as available for conducting cancer detection examinations on a private basis, those practitioners who have served a specific "apprenticeship."

As these clinic examinations are entirely a Public Health problem, as all findings are reported back to the patient's physician for treatment, and as assured attendance by the examining physician is required at each clinic, the Committee decided that the examining physician and director shall be paid for their time. The house staff of the hospitals will not be paid since this will constitute a part of their education program.

2. *Equipment.* No specific comment.

3. *Patients.* At present, the District of Columbia is a separate division of the American Cancer Society. This division does not include any of the surrounding areas; i.e., Montgomery and Prince Georges Counties are in the Maryland Division; and Alexandria and Arlington are in the Virginia Division. The money raised in these neighboring counties goes to Baltimore and Richmond respectively for distribution, and only a very small proportion of it may find its way back to those areas of Metropolitan Washington which are just over the District line. On the other hand, many of those contributing to the American Cancer Society through their place of business live outside the District boundaries. The Committee has tried to make these facilities available to those who have contributed to their support and therefore accept individuals from outside the District boundaries on the same basis as those within the District, provided that they work or have a business within the District. Obviously, the ideal solution is to change our geographical boundaries from the District of Columbia to include Metropolitan Washington. This has been done with other similar groups. It was suggested that this matter should receive prompt and vigorous action by members of both the National and District of Columbia Division of the American Cancer Society.

The Committee felt that these clinics should be available to all individuals, but that those who have no permanent interest in the District of Columbia should be required to pay fully for this service in so far as they are able.

4. *Records.* While standard record forms were recommended by the Committee, it was considered advisable to wait until these standard forms are available from the national offices of the American Cancer Society.

5. *Disposition of Examinees.* The Committee dedecided to confine the extent of each examination to that outlined. Any and all other studies must be carried out by either the physician or clinic whom the examinee may select. This will aid in the education of many of the physicians whom the examinee may select, and will prevent any one clinic from overextending itself. It is worth repeating that these are examining clinics and not diagnostic or treatment clinics. It was also decided that all examinees who have no physician be referred to the MEDICAL BUREAU, which will furnish a list from which to choose.

6. *Fees.* It was agreed that the ideal solution in financing these clinics would be to obtain the required funds entirely from a source such as the American Cancer Society. However, when it is realized that the cost of operation of a detection clinic on each of two half-days a week, examining about 30 new individuals each week, and meeting the standards previously outlined, is slightly in excess of $20,000 a year; and when it is realized that the money available for local use on these projects for the next year is only $25,000, it becomes apparent that some other source of income must be forthcoming. On the other hand, it is not advisable to make the cost of an examination so high as to discourage examination. The compromise has been to encourage the contribution of at least ten dollars ($10.00) by each examinee. This will keep the deficit of each clinic within limits which may be met by the funds available.

It is worth noting that the deficit on each clinic could be decreased by expanding each unit to work at full capacity. However, as a large part of this program is one of education of physicians as well as laymen, and as almost none of the present hospitals has or could furnish space for a full-time clinic, it seems advisable to encourage these smaller and less economical units in as many hospitals as is feasible at present. This likewise will make these clinics more easily accessible to the examinees in all areas of Washington.

The District of Columbia Health Department is contemplating at least one cancer detection unit. Its place in the general program has not yet been determined, but it should be coördinated with this program.

THE GARFIELD LADIES AID CANCER PREVENTION CLINIC

During the period of January through June 1947, this clinic had examined 150 individuals. Certain facts have been accumulated and certain information gained which proved interesting and should be of value to those organizing or contemplating similar clinics.

Eligibility for Examination

It was discovered almost at the onset that neither the general physician nor the layman understood that a cancer prevention (detection) clinic shall examine only those individuals who believe they do not have cancer and who have no symptoms which suggest that they may have cancer. These are not cancer diagnostic and/or treatment clinics, but serve to examine, periodically, well individuals with a view to finding totally unsuspected cancer. Despite a full-time secretary who makes every attempt to explain this to all those requesting appointments, incidents such as the following do occur.

Case 1. A female, aged 54, had been on the list for a cancer detection examination for several weeks. Her appointment was still in the distant future. She called the clinic secretary to say that she hated to wait so long as "this spot" on her tongue was "getting bigger all the time." She was immediately referred and placed under adequate medical facilities. Subsequent follow-up data disclosed that she had a squamous carcinoma of the tongue.

Just one such example is sufficient to impress any and all with the need to educate every one that any of the danger signals of cancer require immediate medical aid and are not in the province of a cancer detection clinic. But this is not realized even by a good number of the physicians in Washington, as this clinic has had calls from a number of physicians who wished to refer patients with such symptoms to the Cancer Prevention Clinic.

It seems worth repeating and emphasizing the difference between various types of cancer clinics:

A Cancer Prevention (Detection) Clinic accepts only individuals who do not have cancer and who do not think they have either cancer, or any symptoms suggestive of cancer. These clinics are for periodic examination only and not for the diagnosis and treatment of cancer. They shall detect "silent," unsuspected cancers.

A Cancer Diagnostic and Treatment Clinic accepts individuals who think they have cancer, or who have symptoms suggestive of cancer, or who have or have had proven cancer. These clinics perform all the procedures necessary for an accurate diagnosis of cancer and for evaluation of the proper form of treatment, and have facilities for carrying out the required treatment.

The Need for Established Facilities to Encourage Physicians to Perform Periodic, Relatively Complete Physical Examinations

The clinic secretary has interviewed examinees at the time of entry and collected answers to the following questions:

(1) When was your last complete physical examination?

(2) What type of physician did your last complete physical examination?

(3) Was your larynx examined by use of a mirror?

(4) Was a pelvic and rectal examination included in the complete physical examination?

(5) Did the examinee ever go to a doctor and request a routine physical examination and (if so) did the examinee get the physical examination requested?

(6) Did the examinee see a physician for any reason within the last 12 months?

The results of these queries are tabulated in table 1. In all instances in which there was any doubt as to an answer, it was disregarded. The statistics were gathered on roughly 150 individuals and, while not verified by any cross check, are thought to be reasonably accurate.

From the data at hand, it is apparent that only one in four individuals had what they considered a complete physical examination within the last 12 months. But it is also apparent that if we define as a complete physical examination the type which is outlined for cancer detection work, the number is much less, because the complete physical examination included a pelvic and rectal examination in only two thirds of the cases, and an examination of the larynx and hypopharynx in only one seventh of the cases. If we include a proctoscopy in all individuals over 35 years of age as a requirement, it is doubtful if any had a complete examination. It was startling for us to realize that even though about 40 per cent of the individuals had requested such a routine examination, only 2 out of 3 who requested this were able to arrange for it by a direct approach.

It should be apparent at once that there is a need for facilities where an individual can readily obtain these periodic examinations. It is also apparent

TABLE 1

Replies to 150 Queries Regarding Physical Examinations

	No.	Per cent
(1) Time of last complete physical examination:		
Never had one	21	15
More than 10 years ago	13	9
Less than 10, but more than 5 years ago	21	15
Less than 5, but more than 1 year ago	53	37
Less than 1 year ago	37	24
	145	
(2) Last complete physical examination done by:		
Medical man and/or family physician	100	81
Surgeon	21	17
Obstetrician	1	1
Gynecologist	1	1
	123	
(3) Did examinee ever request a prophylactic physical examination prior to this time?		
Yes	60	40
No	90	60
	150	
(4) When the examinee had requested a prophylactic physical examination, was he given one?		
No	20	34
Yes	40	66
	60	
(5) Was a physician consulted in the last 12 months?		
Yes	113	78
No	32	22
	145	

that the doctors shall be encouraged to perform these examinations as, although 78 per cent of the examinees questioned had consulted a physician for some reason within the past 12 months, in only one quarter was a reasonably complete physical examination done even though the individual considered himself ill at the time he sought medical aid.

The small number of complete physical examinations performed by the average physician is probably attributable to several factors:

1. While the patient would often appreciate a complete physical examination, he has not been educated to the fact that such an examination is more costly than a routine "office visit."

2. Many patients are more pleased with a simple remedy for a self-limited but uncomfortable illness than to be told after a somewhat detailed study that he is in good physical condition.

3. Many physicians have not been educated to the fact that the signs and symptoms of cancer as given in the usual textbook and medical school curriculum are those of advanced cancer and that, in almost every instance, early cancer can be found only by thinking of cancer and looking for cancer, as early cancer causes no symptoms.

FOLLOW-UP STUDIES ON CANCER DETECTION PATIENTS

As a cancer detection clinic can only examine an individual and report the findings to a doctor of the examinee's choosing, it becomes apparent that the success of such a program will depend to a large degree on the coöperation of the physician contacted. In most instances, coöperation has been excellent, but the need for education of some physicians is still apparent. Although it is obvious to anyone

TABLE 2

Abnormal Findings in 150 Individuals Examined

Cancers:	
Cancer of uterine fundus	1
Cancer of female breast	2
Basal cell cancer of skin	1
Total	4
Benign tumors:	
Thyroid adenoma	2
Lipoma (large)	2
Chronic mastitis	3
Cystadenoma of ovary	1
Erosion of uterine cervix	6
Hypertrophied nodular prostate	1
Multiple neurofibromata	1
Total	16
Dilatation and curettage suggested	7
G.I. X-ray studies suggested	18
Total Individuals Examined	150

who will familiarize himself with the problem that any chance for early detection of gastric cancer depends on roentgenologic examination of the stomach at the first suggestion of indigestion, or weight loss, or loss of appetite, in an individual over 40 years of age; still such advice when given by the detection clinic has been disregarded by some physicians and occasionally ridiculed. Likewise, even though anyone familiar with the early recognition of cancer of the cervix knows that one cannot differentiate clinically between a benign and an early malignant erosion of the cervix, suggestion that an adequate biopsy precede definitive treatment of a small erosion has often been ignored. (Is this due to the cost of laboratory reports, or to lack of facilities in the usual doctor's office for obtaining a cervical biopsy and getting it to the laboratory?)

Results of Examinations

While it is early to tabulate the results of the examinations, a partial list of our findings indicates that the general average of 1.5 cancers per 100 well individuals examined is found also in the District of Columbia (see table 2).

THE EDITOR COMMENTS ON SECRETARIES AND EDITORS CONFERENCE

The Society has due cause to be proud of its Secretary, Theodore Wiprud, who was Chairman of the Program Committee for the Annual Conference of State Medical Association Secretaries and Editors held in Chicago, November 7 and 8. Mr. Wiprud was elected the first lay presiding officer by the Conference.

Your Editor was greatly impressed with the excellence of the program, which was unusually interesting and informative. A new feature was a series of round table discussions on public relations, relations with labor, federal and state legislation, rural medicine, and planning and conducting state medical conventions. A very fine presentation on the subject, "Effective Scientific Programs," was made at one of the general sessions by a member of our Society, Dr. Oscar B. Hunter.

A highlight of the meeting was a State Medical Journal Clinic on November 7, following the usual dinner for the editors, with Mr. Wiprud as moderator. Four state medical journals (*California Medicine*, the *Connecticut State Medical Journal*, the *Ohio State Medical Journal*, and the *Wisconsin Medical Journal*) had been selected for "dissection" and constructive criticism. The subject of format and typography was handled by Mr. Robert H. Roy, Chief Engineer of the Waverly Press and Associate Professor of Industrial Engineering at Johns Hopkins University; Mr. Harry Shaw, General Editor of Harper and Brothers, covered the literary aspects; Mr. John Storm, Executive Editor of *Hospitals*, discussed editorials; and Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association*, reviewed the scientific materials of the "patient" journals. The discourses were scintillating, entertaining, and instructive.

The Secretaries Forum followed a dinner for the secretaries the same evening. Dr. Julian P. Price, Secretary of the South Carolina Medical Association, was the moderator. Subject of discussion: "How Can the Activities of the American Medical Association and State Medical Societies Be Better Coördinated?" Participating in the forum were Dr. Creighton Barker, Secretary of the Connecticut State Medical Society; Dr. P. T. Talbot, Secretary of the Louisiana State Medical Society; Mr. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association; and Dr. Frank J. Milloy, Secretary of the Arizona State Medical Association. General discussion was led by Dr. George F. Lull, Secretary and General Manager of the American Medical Association.

The second day of the Conference was devoted to reports of the moderators of the round tables and to an address by Dr. Louis H. Bauer, member of the Board of Trustees of the AMA, on the World Medical Association.

W. M. Y.

Queries and Answers

Q. *What is the present position of papaverine therapy in (1) angina pectoris, (2) coronary insufficiency, and (3) coronary thrombosis?*

A. (1) In angina pectoris papaverine is probably of little or no benefit.

(2) Papaverine ½ to 1 grain intramuscularly every 4 hours is probably very helpful in many patients. This dosage schedule should be kept up for a day or two after the patient has had the last pain while at complete rest. It is probably worth while to try doses of 1 grain 3 times a day by mouth for a week or 10 days after the last chest pain has occurred while the patient was at rest. However, the value of this drug when given by mouth is uncertain.

(3) One of the important uses of papaverine, if not the most important, is in a case of recent coronary thrombosis (within 24 hours). Papaverine hydrochloride, ½ to 1 grain given slowly intravenously if the patient is still having pain, or every 4 hours intramuscularly if the pain has ceased, is worth while. It has been repeatedly shown in animals that papaverine intravenously will diminish the size of experimental myocardial infarction. Papaverine should be given cautiously when given intravenously, for the writer knows of at least 2 deaths due to injection of this drug by this route. It is well to continue the use of this drug intramuscularly for a day or 2 after coronary thrombosis has occurred.

Q. *Case history: 11-year-old boy. No symptoms. Physical examination and family history negative. Pirquet—positive; chest X-ray—negative. Would further tuberculin skin tests be indicated? If so, which, and at what intervals? Are repeated chest films indicated? If so, at what intervals, and for how long?*

A. Additional tuberculin skin tests are not necessary since no supplementary information can be obtained from their results. Once tuberculin sensitivity is demonstrated it remains unchanged in over 90 per cent of the individuals tested.

Since tuberculin sensitivity may have developed very recently, it is possible that there has been insufficient time for roentgenographic evidence of an active primary complex to demonstrate itself. It would, consequently, be advisable to re-X-ray the patient in 4 to 6 weeks. If the latter does not disclose active pathology, no further X-ray examinations are indicated until the individual reaches the late teens, at which time yearly chest films are recommended as they are for all adults with positive tuberculin reactions. Reinfection tuberculosis is rare in children.

Of course, an attempt should be made to determine the source of this infection by screening all intimate contacts.

Q. *A clinical pathologist desirous of starting a laboratory in the vicinity of Washington would like to know whether selling stock in his business to participating physicians would be considered ethical. Is this a form of fee-splitting?*

A. This question apparently presupposes the formation of a stock corporation which would seem to have a profit object. The issuance of stock would contemplate that profits are to be distributed in the form of dividends. It has long been considered unethical for physicians to permit their patients to become the patients of a person, not authorized to practice medicine, and to have the fees paid for medical service payable to that person. Where a corporation is formed and is capitalized so that stock is issued, and this stock is distributed to participants, in such circumstances the patient might very well become the patient of the corporation and would pay fees for service to the corporation. Such an arrangement is usually considered unethical and in many instances illegal, for the reason that the corporation cannot qualify under the licensured laws regulating the practice of medicine. Before a complete answer to such a question could be given, the corporate plans would have to be submitted to a competent attorney for an expression of opinion thereon. The issuance of stock might be considered a form of fee-splitting under certain circumstances, but a full answer to this aspect of the question can be given only after the corporate plan is analyzed and considered in connection with the laws of the state where the corporation is to function.

Q. *Please indicate the dosage schedule in transferring a patient already digitalized with a rapidly eliminated glycoside to the standard dried leaf digitalis preparation.*

A. The usual maintenance dose of dried leaf digitalis is one tablet of 1½ grains, and this would be about the correct maintenance dose in a digitalized patient whether he had been digitalized by a rapidly eliminated glycoside or by a dried digitalis leaf preparation. It is well to bear in mind that digitalis is now supplied in U.S.P. units rather than cat units. A U.S.P. XII unit is about 25 per cent stronger than a cat unit. Therefore, one U.S.P. unit daily may be a little too much as a maintenance dose for some patients.

Washington Physicians of Yesterday

JAMES DUDLEY MORGAN, A.B., M.D.

Noteworthy for his historical associations and interests, as well as for his prominence as a physician, Dr. James Dudley Morgan was a native of Washington, born July 5, 1862. From Georgetown University he received the degree of A.B. in 1881, and of M.D. in 1885. He continued his medical studies at Bellevue Hospital, in Paris 1885–86, and under Dr. William Osler. Thereafter for the remainder of his life he engaged in the general practice of medicine in the city of Washington, D. C. In the Georgetown University Medical School he was Demonstrator of Anatomy 1888–89, and Lecturer on Differential Diagnosis 1897–98; and in the George Washington University Medical School he was Associate and Clinical Professor of Medicine 1910–17. He rendered hospital service in Children's Hospital 1885, Georgetown University Hospital, Garfield Hospital 1899–, and Emergency Hospital 1904–. He was a member of a number of local and national medical and scientific societies, and served as Secretary of the District of Columbia Medical Association 1891–95, and President of the District Medical Society 1906. He was also a member of the Cosmos, Metropolitan, and Chevy Chase Clubs, and was memorialized in "Who's Who in America" and in "American Men of Science." He was author of a number of contributions to medical and historical literature.

He married Mary Abell December 2, 1892; and he died November 21, 1919, leaving three sons and one daughter.

(Continued on page 718)

SOCIETY MEMBER INVENTS PORTABLE FLUSHING BEDPAN

After 11 years of study and experimentation, Dr. Isadore Levin, Chief of Physical Therapy at Doctors Hospital, has invented a portable flushing bedpan which can be installed in almost any present-day hospital. Charles Stohr, X-ray technician at Doctors Hospital, aided Dr. Levin in solving mechanical problems.

The multiple-purpose toilet, as Dr. Levin calls it, can be used between two ward beds, next to the bed, or on the bed like a conventional bedpan. Because of its standard connections, the portable bedpan can be installed in place of a toilet by any plumber. The original model of the patented device has been in use at Doctors Hospital for the past nine months.

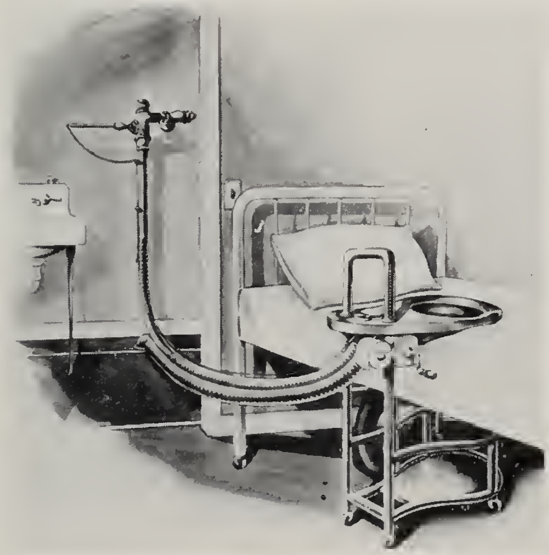

Fig. 1. Toilet raised to position in bed as flushing bedpan.

By use of flexible expanding tubes, the portable bedpan can be moved several feet from built-in plumbing outlets. Mounted on a solid base, it can be raised on stainless steel bars to bed height for conventional bedpan use (fig. 1), or it can be utilized in its lowered position like a toilet (fig. 2). Attached to the bedpan is a flushing valve that can be operated by the patient.

The new invention, according to Dr. Levin, eliminates all carrying and lessens embarrassment to the patient. Besides being exceptionally wide, the pan is supported by braces and cannot upset. A specially designed bowl and drain prevent overflow, even during an enema or colonic irrigation.

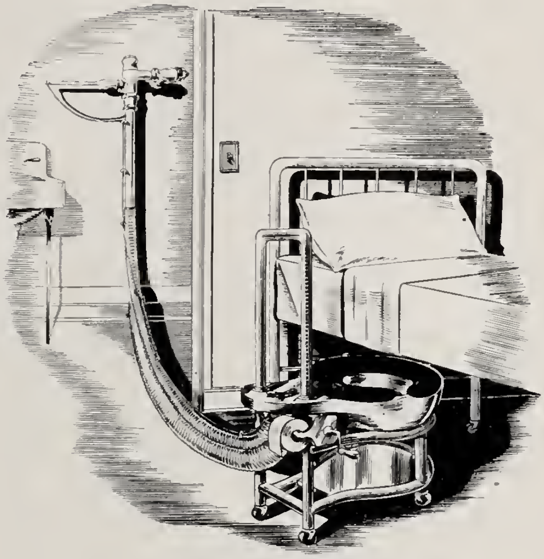

Fig. 2. Toilet in place as bedside commode.

For the ambulatory but weak patient who prefers not to use a bedpan, the device can be used beside the bed as a regular toilet without undue walking.

Dr. Levin has received a letter from the District Inspector of Plumbing commending the portable toilet as a "sanitary fixture with beneficial aid to all hospitals."

CORRESPONDENCE

Washington, D. C., November 2, 1947

To the Editor,
Medical Annals of D. C.
1718 M Street, N.W.
Washington. D.C

Sir:

The report by Ciocco, A., and Altman I., "A Postwar Survey of Physicians Practicing in Washington," the Annals, October, 1947, is both interesting and valuable.

There is, however, one fallacy which should be noted; namely, that the patient load in June, 1947 is compared with that in February, 1945, as well as with that of September, 1942. It is likely that the patient load is much less in June than in February, because in the latter month there is invariably an increased incidence of respiratory infections, and possibly of other illnesses.

Very truly yours,

M. D.

News and Personals

The American College of Surgeons has announced six Sectional Meetings to be held during the early part of 1948 for Fellows of the College, the medical profession at large, and hospital personnel. Each meeting will be two days in length and will include conferences for hospital personnel as well as sessions for the medical profession. The two meetings which will be held closest to Washington are Toledo, January 20 and 21, at the Commodore Perry Hotel, and Atlanta, January 26 and 27, at the Ansley Hotel. Details of the program to be presented may be secured from Mr. L. G. Jackson, American College of Surgeons, 40 East Erie Street, Chicago 11, Ill.

The Interim Session of the House of Delegates of the American Medical Association will be held in the Cleveland Auditorium, Cleveland, January 7 and 8. The Medical Society's Delegates, Dr. Coursen B. Conklin and Dr. Herbert P. Ramsey, and Theodore Wiprud, Secretary of the Society, are planning to attend the sessions.

The Council on Industrial Health of the AMA will convene for its eighth annual meeting in Cleveland, January 5 and 6, immediately preceding the Interim Session of the AMA.

General practitioners are cordially invited to attend these industrial health sessions since the program is being planned with them in mind. The program will include discussions of first aid and emergency services in industry, physical examinations, administrative practices, applied physiology, aviation medicine, radiation medicine and practical expositions of occupational disease management, traumatic surgery and rehabilitation.

The Third Pan American Congress on Ophthalmology will be held in Havana, Cuba, January 4 to 10, 1948, at the University of Havana School of Medicine. Among the speakers will be Colonel J. E. Ash of Washington, D. C.

CALENDAR OF MEETINGS

November 1	Washington School of Psychiatry
November 2	General Practitioners
November 3	Committee on Compensation Insurance
	Washington Ophthalmological Society
November 4	Committee on Public Health
	D. C. Dietetic Association
November 5	Board of Trustees, Medical Service
November 6	Section on Neurology and Psychiatry
November 8	Washington Psychoanalytic Society
November 11	X-ray Technicians of Washington
November 12	Scientific Meeting of Society
	Board of Trustees, Medical Service
	Woman's Auxiliary
November 13	District Dental Society
November 14	Membership Committee
November 17	Washington Orthopedic Club
November 18	D. C. Medical Technicians
	Washington Metropolitan Health Council
November 19	Scientific Meeting of Society
	Washington Diabetes Association, Inc.
November 20	Section on Anesthesiology
	Program Committee
November 21	Subcommittee on Venereal Disease
November 24	Executive Board
November 25	Physician-Veterans of World War II

The first annual presentation of unusual cases will be given by members of the **Silver Spring Academy of Medicine** on January 5. The following program has been arranged, with a time limit of five minutes for each presentation:

"Traumatic Rupture of Renal Artery," Dr. John Brownsberger

"Color Motion Picture of Operation for Double Urethro-Vaginal Fistulae with Atresia of Vagina," Dr. Read N. Calvert

"Cerebral Aneurysm," Dr. Katherine A. Chapman

"Shoulder Presentation with Rupture of Uterus," Dr. L. Marshall Cuvillier, Jr.
"Mastoidectomy under Local Anesthesia," Dr. Peter Lombard
"Fundus of Boy with Malignant Hypertension," Dr. C. R. Naples
"A Case of Bronchiectasis," Dr. James J. Feffer
"Frank Breech-Hydrocephalus-Spina Bifida-Meningocele—Caesarian Section," Drs. F. G. Leslie and R. B. Phillips
"Malignant Tumor in Breast of Child of Five," Dr. Mario Scandiffio
"Coronary Disease in the Presence of Duodenal Ulcer," Dr. Aaron H. Traum
"Acute Frontal Sinusitis Complicated by Meningitis," Dr. H. K. Vann
"Pernicious Anemia—Sedimentation Rate with Anti-reticulo-cell Serum," Dr. William B. Wardrop
"Tumor of Neck," Dr. Frank A. Zack

Additional cases will be presented by Drs. Mitchell, Shoemaker, Norcross, Schultz, Spence and others.

Physicians who receive their AMA Directory Information Card will note the rectangular holes punched on the right hand side of the card, and, above the holes, at the top of the card, a series of figures. This number, ignoring the last digit, is the new serial number which the Bureau of Medical Economic Research has assigned to each living physician. This number is unique and will not be given to another physician when the first one dies.

This numbering system is needed by the Bureau in its research work because the task of keeping track of more than 225,000 punch cards is difficult unless the IBM equipment can utilize a number instead of a name. Actually there will be four punch cards for each living physician. The first card carries only the name of the physician, the second card contains the street address, and the third, the city, postal zone (where available) and state. The fourth card is purely statistical. This will give the Bureau a continuous inventory containing almost all the items in the directory. In the event of a national emergency this information could be made available within a very short time.

Physicians throughout the Nation are being asked to furnish medical evidence to substantiate the claims of railroad workers who may now draw cash sickness benefits under the **Railroad Unemployment Insurance Act.** The Railroad Retirement Board pointed out that unless an application is mailed not later than the seventh day after the first day of sickness claimed, it may not be received within the legal time limit for filing applications. As a result, the employee may lose one or more days' benefits. Doctors are asked either to return each completed Statement of Sickness to the patient, or mail it promptly to the office of the Board to which it is addressed.

The Seventh Annual Physicians' Golf Tournament was held October 16 at the Kenwood Golf and Country Club. In spite of inclement weather, forty-six physicians and friends gathered to display their skill at golf, and most of them stayed for the dinner which rounded out the day. At the dinner prizes were awarded to all the players. A list of the prize winners follows:

1st low gross, John W. Nesbitt; 2nd low gross, Leo B. Gaffney; 3rd low gross, Frank A. Zack; 4th low gross, Richard Fischer; 5th low gross, Clayton Hawfield; 1st low net, Russel J. Jansen; 2nd low net, Richard J. McNulty; 3rd low net, Howard H. Strine; 4th low net, Bill Walper; 5th low net, Samuel Zola.

Blind bogie: Jeter C. Bradley, A. J. Obert, S. Ross Taggart, James P. Kane, Leonard Berman and Fred R. Sanderson.

Tie for low score on any hole, Allen Lloyd and James Hawfield; highest score on any hole, Preston Haynes; 2nd high on any hole, W. R. Perkins, Jr.; 3rd high on any hole, Samuel Zola; highest handicap, Benjamin Golden; lowest handicap, Steve Pridgen; highest score, J. J. B. Sebastian.

A special prize was awarded Theodore Wiprud, Secretary of the Society, in the form of a War Savings Bond for his work in connection with the tournament.

Participating golfers are indebted to the following firms who contributed prizes for the tournament:

Ayerst, McKenna and Harrison, Marion S. Alley, Camel Cigarettes, Chestnut Farms Dairy, Corwin's Pharmacy, East Capitol Pharmacy, Gibson's, Good Hope Pharmacy, Huffer-Shinn Optical Company, Kloman Instrument Company, Lee Funeral Service, S. G. Leoffler Operating Company, Maxwell & Tennyson, Peoples Drug Stores, Roane's Pharmacy, Service Pharmacy, Frank R. Strunk, Tipton & Myers, Tirella, Inc., Tschiffely's, Waldman Doak Company, Whitman Company, Wilkins Coffee Company, and Williams Drug Store.

At the meeting of the **Executive Board,** October 27, **Drs. Richard T. Sullivan and J. Ross Veal** were reappointed Delegates to the Federation of Citizens' Associations, representing the Medical Society.

The Section on Otolaryngology met at the Washington Society for the Hard of Hearing, October 24, to hear reports on that organization's activities to help the deaf.

The Washington Diabetes Association, Inc., held an all-day meeting in the Medical Society's auditorium, November 19, which attracted a capacity audience at each of three sessions. Dr. Charles H. Best, of Toronto, Canada, co-discoverer of insulin, and Dr. Elliott P. Joslin, Boston, eminent authority on diabetes, were the speakers.

Invitations were issued to interns and medical students for the first session, when Dr. Joslin spoke on "The Treatment of Diabetes" and Dr. Best discussed "Insulin, Histamine, Heparin and Choline."

At a special meeting for laymen in the afternoon, Dr. Best gave a talk on "Insulin—Past, Present and Future," and Dr. Joslin, "The Diabetic, His Family and the Community." Officers of the Association estimated that approximately 800 people were present at this meeting.

Doctors filled the auditorium in the evening to hear Dr. Best's address on "Advances in Carbohydrate Metabolism" and Dr. Joslin's on "The Magnitude of the Diabetes Problem and Its Solution."

Dr. John A. Reed, President of the local Diabetes Association, received merited congratulations for the success of this three-session program.

The program of the **George Washington University Medical Society,** November 15, was devoted to "The Diagnosis and Treatment of Pneumonia." Following case presentations by Dr. Mark H. Lepper, discussion was led by Drs. Harry F. Dowling, Clayton B. Ethridge, James J. Feffer and George W. Wyatt.

Members of the **Clinico-Pathological Society** were guests of Dr. Lee McCarthy, November 18, at the Kennedy-Warren Apartments. Dr. Walter W. Boyd read a paper on "Nausea and Vomiting of Pregnancy."

New officers of the Society are:

Dr. John H. Lyons, *President;* Dr. Daniel B. Moffett, *First Vice President;* Dr. Arch L. Riddick, *Second Vice President;* Dr. Theodore J. Abernethy, *Secretary.*

A new organization, to be known as the **Tri-State Allergy Society,** was organized on October 24 at the Army-Navy Club. Membership includes physicians specializing in allergy who are practicing in Maryland, Virginia and the District of Columbia. The following officers were elected to serve for the ensuing year:

Dr. Harry S. Bernton, *President;* Dr. W. Ambrose McGee, Richmond, *Vice President;* Dr. Frank F. Furstenberg, Baltimore, *Secretary-Treasurer.*

The Metropolitan Washington Tuberculosis Conference held its fall meeting, November 13, at Howard University School of Medicine. X-ray films were presented to the Medical Section, followed by comments on each by Dr. A. C. Christie and Dr. Ira Lewis, Senior Surgeon of the Tuberculosis Control Division of the USPHS.

Dr. V. L. Ellicott, Health Officer of Montgomery County, was elected President of the Conference; Dr. Howard M. Payne, Associate Professor of Medicine at Howard University School of Medicine, Vice President; and Miss Rebecca Sweeney, Director of the District Tuberculosis Association's Professional Information Service, Secretary.

The Washington Ophthalmological Society met November 3 in the Society's building. The guest speaker, Dr. Paul Chandler, of Boston, addressed the Society on "Practical Considerations in Glaucoma." The late Dr. Louis S. Greene gave a case presentation on "Bilateral Occlusion of Central Retinal Artery."

In his Presidential Address before the **Washington Medical and Surgical Society,** October 27, at Hotel 2400, Dr. Norman C. Shoemaker cited unusual cases from his own experience which required a better understanding of professional ethics than professional ability.

Officers elected for the coming year were:

Dr. Leo B. Gaffney, *President;* Dr. Joseph Belair, *Vice President;* Dr. J. Keith Cromer, *Secretary.*

Dr. Frank E. Gibson is Permanent Treasurer.

The Association of the Honorary Consultants to the Army Medical Library held its Fourth Annual Meeting in Washington, October 10 and 11. At the dinner meeting at the Hotel Statler, October 10, addresses were made by Acting Surgeon General George E. Armstrong, Major General Paul R. Hawley, Dr. Walton B. McDaniel, and the newly elected President, Dr. Chauncey D. Leake.

Recently appointed Honorary Consultants by Surgeon General Raymond W. Bliss were Dr. John E. Gordon, Professor of Epidemiology, Harvard School of Public Health; Major General Norman T. Kirk, M.C., U.S.A. (retired); and Tracy S. Voorhees, LL.D., Special Assistant to the Secretary of the Army.

At the meeting of the **Washington Psychoanalytical Society** in the Society's auditorium, November 8, Dr. John N. Rosen spoke on "Direct Analytical Therapy of the Psychoses." Discussion followed, led by Drs. Frieda Fromm-Reichmann and Dexter M. Bullard.

The Jacobi Society, at its first fall meeting, October 20, featured a Symposium on the Early Diagnosis of Malignancy by the Papanicolau Technic. Dr. Charles Aronstein was moderator. Bronchogenic aspects were presented by Dr. David Davis, genitourinary aspects by Dr. Gilbert Ottenberg, and the gynecologic aspects by Dr. Samuel M. Dodek.

The Baltimore-Washington Dermatological Society elected Dr. Reuben Goodman, President, and Dr. Harry M. Robinson, Baltimore, Secretary, for 1947–48.

The Graduate Nurses' Association and the League of Nursing Education sponsored jointly an Institute on Mental Hygiene in the auditorium of the Department of Commerce, November 19 and 20. Presiding at the opening session wass Miss Ashby Taylor, President of GNA. Dr. Addison Duval, Medical Director of St. Elizabeths Hospital, gave an address on "Emotional Growth and Development." Dr. Raymond Schwartz participated in a panel discussion on Interprofessional Relationships and the Patient. At the closing session, Miss Agnes Dix, President of LNE, presided.

The Society's offices have received a sample issue of *ADA Forecast*, a magazine for diabetics, which will begin publication in January 1948 under the auspices of the American Diabetes Association, Inc. The purpose of the new publication is to give the physician an additional aid in the treatment of his diabetic patient.

At the **Twelfth Assembly and Convocation of the United States Chapter, International College of Surgeons,** which was held in Chicago, October 3, the following physicians from Washington were inducted into fellowship in the College: Drs. Clifford E. Bagley, Harry F. Davies, V. S. Lambros, Aaron H. Gerber, Jacob Kotz, Garnet W. Ault, and Brig. General Wallace H. Graham. Dr. Frederic A. Moretti was elected to Associate membership in the College.

Many Society members have been invited to conduct conferences and clinics at the **National Naval Medical Center** in Bethesda. During the last two weeks in November the following physician-members were scheduled to appear on the program:

Drs. Vincent T. Young, Clayton B. Ethridge, Calvin T. Klopp, Lawrence C. Kolb, Roy G. Klepser, Edward B. Tuohy, William P. Herbst, Edmund E. Barksdale, Paul A. Dickens, R. A. Cohen, L. Conner Moss, Edgar W. Davis, Robert J. Coffey, Joseph F. Belair, Ralph M. Caulk, Charles F. Geschickter, William T. Gibb, and Charles S. White.

Major General Norman T. Kirk, M.C., U.S.A. (retired), former Surgeon General of the Army, was awarded the Gold Key of the American Congress on Physical Medicine at its annual meeting in Minneapolis on September 4, 1947. The award is made annually to prominent figures in the international field of medicine who have contributed toward the advancement of the specialty of physical medicine. Others who received the Gold Key at this meeting were Lord Thomas Jeeves Horder, physician to His Majesty the King of England and President of the British Association of Physical Medicine, and Dr. Andrew C. Ivy, Vice President of the University of Illinois, Consultant to the Council on Physical Medicine of the AMA and special consultant to the Secretary of War regarding war crimes of a medical nature.

Mr. J. G. Capossela, Superintendent of Emergency Hospital, was installed President of the **Maryland and District of Columbia Hospital Association** at its seventh annual meeting, November 10.

Brady J. Dayton, Administrator of the Peninsula General Hospital, Salisbury, was named President-elect. Other administrators elected to office were J. H. Nies, Washington Sanitarium and Hospital, Vice President; Sister Veronica, Mercy Hospital, Baltimore, Second Vice President; Sister Marie, Providence Hospital, Third Vice President; Richard R. Griffith, West Baltimore General Hospital, Secretary-Treasurer. Chosen as delegate for Washington was Leo G. Schmelzer, George Washington University Hospital; Dr. John Orem, Sibley, alternate.

Mr. Schmelzer and Dr. Montgomery Blair, Director of Children's Hospital, were among the speakers at the convention.

Major General Paul R. Hawley, Medical Director of Veterans Administration, has been awarded the 1947 Gorgas Medal for his work with VA. The medal, which is contributed annually by Wyeth, Inc. of Philadelphia, was presented to General Hawley at a meeting of the Association of Military Surgeons of the United States, in Boston, November 14.

Dr. Daniel Blain has been appointed Professor of Psychiatry and Director of the Department of Psychiatry of the **Georgetown University School of Medicine.** He served as Lieutenant Commander in the U. S. Public Health Service from August, 1942 until December, 1945, when he was detailed to the Veterans Administration as Assistant Medical Director, Chief of the Division of Neuropsychiatry. He was discharged from service on July 1, 1946. Dr. Blain has been associated with the staffs of Peter Bent Brigham Hospital, Boston City Hospital, Austen Riggs Foundation, Silver Hill Sanitarium, Tratelja Farms Sanitarium, and Blythewood Sanitarium.

Another recent Georgetown appointment of considerable interest is that of **Dr. Paul Kiernan** as Associate Professor of Surgery. Dr. Kiernan, a graduate of the George Washington University School of Medicine, was appointed Fellow in Surgery at the Mayo Foundation and later became Assistant Surgeon at the Mayo Clinic. He was a member of the staff and head of the Section in General Surgery at the Mayo Clinic and a Consultant in Surgery of the Affiliated Hospitals of the Mayo Clinic. He received the degree of M.S. in Surgery in 1944 from the University of Minnesota.

Dr. Wallace M. Yater, Director of the Yater Clinic, visited the Mayo Clinic at Rochester following the Secretaries and Editors Conference in Chicago, November 7 and 8. On November 12 he was invited to Louisville, Kentucky, to give the Samuel D. Gross Lecture at the Louisville General Hospital. On the following day he made ward rounds with the Dean of the University of Louisville School of Medicine and the staff of the Department of Medicine. At noon of the same day he gave a lecture to the medical students of the University of Louisville.

Dr. Yater also delivered two lectures before the Cabell County Medical Society at Huntington, West Virginia, December 11, one on "Constrictive Pericarditis" and the other on "Coronary Artery Disease in Young Men."

Dr. Joseph T. Roberts has been appointed Professor of Medicine at the University of Arkansas School of Medicine at Little Rock, to assume his new duties December 1. Dr. Roberts will be Dean and head of the Department of Medicine as well as Director of the University Hospital.

Since 1943 Dr. Roberts has been Chief Medical Officer in Medicine at Gallinger Municipal Hospital and Adjunct Clinical Professor of Medicine at Georgetown University and George Washington University Schools of Medicine.

Dr. Walter A. Bloedorn assumed the presidency of the Association of American Medical Colleges at its 58th annual meeting in Sun Valley, Idaho, October 28 and 29. Dr. Bloedorn is the first District medical administrator to hold the office of President of that organization. Dr. J. Roscoe Miller of Northwestern University is the new President-elect of the Association.

Dr. Frank E. Wilson has been appointed administrator of the **American Red Cross medical services** to succeed the late Dr. Courtney Smith, who was killed in a plane crash last June. Dr. Wilson has been deputy administrator of the services since joining the Red Cross staff in June 1946. As administrator he will be responsible for

ARC's disaster medical and nursing service and employees' health service.

Dr. Wilson is a graduate of the University of Tennessee College of Medicine and the University of North Carolina School of Public Health. Dr. Wilson is a veteran of World War II, completing his service as a Colonel in 1945. He resides in Silver Spring, Md.

Drs. Samuel M. Dodek and Julius R. Epstein prepared a film entitled "Prolapse of the Uterus Complicating Labor" for presentation in September at the American Congress of Obstetrics and Gynecology, held in St. Louis, and at the Assembly of the International College of Surgeons, in Chicago, in October.

Dr. Shields Warren, pathologist at the New England Deaconess Hospital, Boston, and Assistant Professor of Pathology at Harvard, has been named Interim Director of the **Atomic Energy Commission's new Division of Biology and Medicine.** He will serve on a half-time basis until a permanent director is appointed. The new division will correlate programs of medical and biological research in the AEC and in private laboratories and institutions.

At a recent meeting of the AMA's Board of Trustees, **Drs. Oscar B. Hunter and Eugene R. Whitmore** were appointed to represent the AMA at the Fourth International Congress of Tropical Medicine, which will be held in May 1948.

At Doctors Hospital, November 2, **Dr. William Gerry Morgan** gave a brief address to the first graduates, nine in number, who completed a full one-year course in practical nursing in a District hospital.

Dr. Robert J. Coffey presented a paper on "Pathogenesis and Management of Familial Polyposis" before the regular monthly staff medical meeting of Veterans Administration Hospital, November 3.

Captain George B. Dowling, M.C., U.S.N. (retired) has been named deputy administrator of the American Red Cross' national blood program, according to Dr. Ross T. McIntire, chief of the program. Dr. Dowling is a graduate of George Washington University School of Medicine.

Dr. David L. Weinstein and Dr. Harry S. Weitzman addressed the Washington Nurses' Association at its monthly meeting in the Scotts Hotel, November 17.

Dr. O. Benwood Hunter, Jr., addressed the District of Columbia Society of Medical Technologists on the subject of "Hepatograms," on November 18, in the Medical Society's building.

Drs. Leslie V. Dill and V. A. Ujhely are new participants from the Medical Society in the programs of Professional Staff Proceedings at Walter Reed General Hospital.

MEMBERSHIP

The following applicants for membership will be voted on at the meeting of the Executive Board, December 29, 1947:

For Active Membership

Robert C. Haile, Georgetown University—1943
James P. Jarboe, Georgetown University—1942
Shirley Sue Martin, Medical College of Virginia—1943
Elaine W. Murphy, University of Minnesota—1941
Josephine E. Renshaw, University of Maryland—1943
Albert I. Robins, Georgetown University—1941

For Associate Membership

Ronald S. Fleischer, University of Paris—1939

The following applicants for membership will be voted on at the meeting of the Executive Board, January 26, 1948:

For Active Membership

Herbert M. Giffin, Johns Hopkins University—1935
Frank Joseph Grabill, Western Reserve University—1943

For Associate Membership

Lee Jarvis, University of Chicago—1937
Benjamin S. Miller, University of Arkansas—1934
John Otto Robben, St. Louis University—1933
Harvey J. Tompkins, Loyola University—1932
Hewitt Irving Varney, University of Vermont—1935

HOSPITAL STAFF MEETINGS

Hospital	*Day of Month*	*Time*
Alexandria	1st Wednesday	8:15 p.m.
Arlington	1st Thursday	8:00 p.m.
(Meetings held at County Health Dept., 1800 N. Edison St.)		
Casualty	1st Thursday	1:15 p.m.
Children's	1st Monday	1:00 p.m.
Columbia	2nd Friday	8:30 p.m.
Doctors	1st Monday	8:30 p.m.
Emergency	4th Tuesday	12:00 m.
Episcopal Eye, Ear and Throat	1st Friday	8:15 p.m.
Freedmen's	Last Friday	11:00 a.m.
Garfield	1st Wednesday*	12:00 m.
George Washington	1st Monday after 1st Tuesday	12:15 p.m.
(Meetings held at 1335 H St., Hall A)		
Georgetown	1st Tuesday	12:00 m.
Glenn Dale	Every Tuesday	1:00 p.m.
Homeopathic	3rd Tuesday	1:00 p.m.
Mount Alto	1st Monday	8:30 p.m.
Naval	Every Friday	1:00 p.m.
Prince Georges	3rd Tuesday	8:30 p.m.
	Last Sunday	11:00 a.m.
Providence	2nd Tuesday	9:00 p.m.
	3rd Tuesday	11:30 a.m.
Saint Elizabeths	Every Tuesday	11:30 a.m.
(Meetings held in Administration Building)		
Sibley	2nd Tuesday	8:30 p.m.
Suburban	2nd Tuesday	8:30 p.m.
Walter Reed	Every Saturday	11:00 a.m.
Washington Sanitarium	3rd Monday	8:00 p.m.

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* February, May, October and December.

NOTE: Except where indicated the meetings are held at the hospital.

BOOK REVIEW

Internal Medicine in General Practice, 2nd ed. ROBERT PRATT McCOMBS, B.S., M.D., F.A.C.P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. Price, $8.00. Pp. 741, with 122 illustrations. Philadelphia: Saunders, 1947.

In this second edition of his work McCombs adheres to his former policy of presenting only the basic principles of everyday problems in internal medicine. By this method the author achieves a brevity and lucidity that are lacking in the larger textbooks of medicine. On the other hand a considerable sacrifice of material is necessarily entailed, so that this smaller volume cannot replace the longer works. Rather it would seem to be a valuable supplement in the education of students and refreshing review for the general practitioner.

Considering the technical difficulties which must be surmounted in the publication of any book these days, the entire work is amazingly up-to-date. The various chapters are followed by lists of references which are well chosen because they are mainly from the recent literature and enlarge the scope of the text.

The value of the work is further enhanced by 122 illustrations, carefully selected and executed. In addition, classifications of diseases and tables relating to differential diagnosis and similar points are well done in accordance with modern concepts.

H. H. H.

BOOKS RECEIVED FOR REVIEW

Acknowledgment is made of the following books which have been received for review:

Diseases of the Nose, Throat and Ear, 9th ed. WILLIAM LINCOLN BALLENGER, M.D., F.A.C.S., Late Professor, School of Medicine, University of Illinois, Chicago, AND HOWARD CHARLES BALLENGER, M.D. F.A.C.S., Associate Professor and Acting Chairman of the Department of Otolaryngology, Northwestern University School of Medicine, Chicago; Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois, assisted by JOHN JACOB BALLENGER, B.S., M.D., Research Fellow in Otolaryngology, Northwestern University School of Medicine, Chicago. Price, $12.50. Pp. 993, with 597 illustrations and 16 plates. Philadelphia: Lea & Febiger, 1947.

A Primer of Cardiology. GEORGE E. BURCH, M.D., F.A.C.S., Associate Professor of Medicine, Tulane University School of Medicine; Senior Visiting Physician, Charity Hospital; Consultant in Cardiovascular Diseases, Ochsner Clinic; Visiting Physician, Touro Infirmary, New Orleans, AND PAUL REASER, M.D., Instructor in Medicine, Tulane University School of Medicine; Assistant Visiting Physician, Charity Hospital, New Orleans. Price, $4.50. Pp. 272, with 203 illustrations. Philadelphia: Lea & Febiger, 1947.

Unipolar Lead Electrocardiography Including Standard Leads, Unipolar Extremity Leads and Multiple Unipolar Precordial Leads. EMANUEL GOLDBERGER, B.S., M.D., Adjunct Physician, Montefiore Hospital, New York; Cardiographer and Associate Physician, Lincoln Hospital, New York; Diplomate of the American Board of Internal Medicine; Clinical Lecturer in Medicine, Columbia University, Faculty of Medicine. Price, $4.00. Pp. 182, with 88 illustrations. Philadelphia: Lea & Febiger, 1947.

The Foot and Ankle: Their Injuries, Diseases, Deformities and Disabilities, 3rd ed. PHILIP LEWIN, M.D., F.A.C.S., Associate Professor of Bone and Joint Surgery, and Acting Head of Department, Northwestern University Medical School; Professor of Orthopaedic Surgery, Post-Graduate Medical School of Cook County Hospital; Attending Orthopaedic Surgeon, Cook County Hospital; Senior Attending Orthopaedic Surgeon, Michael Reese Hospital; Consulting Orthopaedic Surgeon, Municipal Contagious Disease Hospital, Chicago; formerly Colonel, Medical Corps, Army of the United States. Pp. 847, with 389 illustrations. Line drawings by Harold Laufman, M.D., F.A.C.S., Associate in Surgery, Northwestern University Medical School; formerly Major, Medical Corps, Army of the United States. Price, $11.00. Philadelphia: Lea & Febiger, 1947.

Blood Derivatives and Substitutes: Preparation, Storage, Administration and Clinical Results Including a Discussion of Shock—Etiology, Physiology, Pathology and Management. CHARLES STANLEY WHITE, M.D., Sc.D., Former Professor of Surgery, George Washington University School of Medicine; Chief of Surgery, Doctors Hospital; Consultant to Garfield Hospital, Providence Hospital, and Columbia Hospital, Washington, D. C., and to U. S. Naval Hospital, Bethesda, Md., AND JACOB JOSEPH WEINSTEIN, B.S., M.D., Associate in Surgery, School of Medicine, George Washington University; Associate in Surgery at Gallinger Municipal Hospital and George Washington University Hospital, Washington, D. C. Price, $7.50. Pp. 484, with 195 illustrations. Baltimore: Williams & Wilkins, 1947.

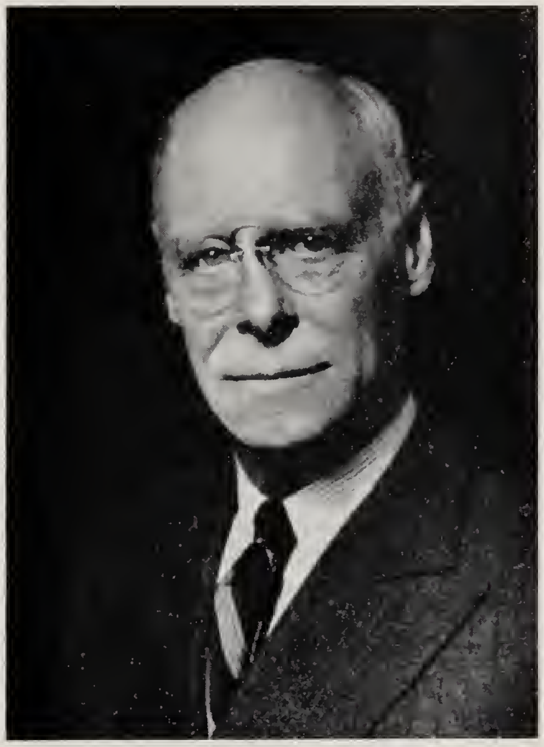
LOUIS STORROW GREENE, M.D., F.A.C.S.

(1872–1947)

Dr. Louis S. Greene, distinguished Washington ophthalmologist, died November 12, 1947, at his home, 2315 Tracy Place, N.W. As a member of the Board of the Episcopal Eye, Ear and Throat Hospital since 1898, and for the past 20 years Chief of Staff of the eye service, Dr. Greene was widely known among eye specialists.

Dr. Greene was born in Columbus, Georgia, November 19, 1872, the son of Colonel William Spencer Greene and Mrs. Anne Storrow Greene. He graduated in medicine from the University of Virginia in 1895. After serving his internship at the University of Virginia Hospital for two years, he came to Washington as assistant to Dr. William H. Wilmer, internationally known ophthalmologist.

During World War I Dr. Greene was head of Selective Service's eye examining service for the District.



LOUIS S. GREENE, M.D.

Dr. Greene became a member of the District Medical Society in 1902 and a Life member in 1943. He was a Fellow of both the American Medical Association and the American College of Surgeons, a Past President of the American Ophthalmological Society, and a diplomate of the American Board of Ophthalmology.

He served as senior warden of All Souls' Episcopal Church for the last 15 years, and was a member of the Chevy Chase Club.

Surviving are his wife, Mrs. Louise Burke Greene; a son, Julian Burke Greene; and a daughter, Miss Anne Carter Greene, all of Washington. For many years Dr. Greene had maintained his office at 1710 Rhode Island Avenue, N.W.

Medical Statesmanship—Bortz

(*Continued from page 656*)

BIBLIOGRAPHY

1. Browning, W.: Men of medical training in Congress (1789–1910). West. M. Times, Denver, Colo., 1919–20, 39, 39.
2. Eagleton, W. P.: Responsibility of medical profession towards political institutions of nation. J. M. Soc. New Jersey, 1942, 39, 68.
3. Browning, W.: Physicians who have been governors of our states, territories and colonies. West. M. Times, Denver, Colo., 1923, **43**, 18.
4. Edwards, L. F.: Medical men as pioneers in nonmedical fields. Ohio State M. J., 1942, **38**, 461.
5. Dictionary of American Biography, Echols to Fraser. New York: Scribner, 1931, **6**, 204.
6. Moynihan, Lord: Physician-authors of past and present. Medical Life, 1935, **A2**, 643.
7. Spencer: Diplomat, January 1941.
8. Prentis, H. W., Jr.: Moving finger writes. J. A. M. A., 1947, **134**, 743.
9. Liebman, J. H.: Peace of Mind. New York: Simon & Schuster, Inc., 1946.
10. Editorial: Medicine in Brazil. J. A. M. A., 1947, **134**, 1427.

Check on Charity—Observer

(*Continued from page 699*)

"The chatelaine of this establishment is a woman of doubtful age who, among others, has a hatred for dogs. Most of the dog owners on the block keep their dogs on the leash and in the middle of the street. She insults the feminine dog walkers, intimating that instead of having dogs they should have babies. She throws lysol upon her next-door neighbors, innocently sitting of an evening in their own back yard. She spies upon a lady connected with the theatrical business who had the temerity to bring home some men to her apartment after an evening rehearsal to discuss changes in the play, shouting insults at her from her window."

When complaints were made, the "charitable organization" that is so tenderly solicitous for the welfare of unmarried mothers replied apologetically that it knew she was not the ideal woman for her position, "but that there was Something in the Terms of the Will that made the Trustees responsible for her upkeep until she died." By lumping her with the unmarried mothers they were "Saving Money for the Benefit of Posterity."

Perhaps a follow-up on charities locally might do some good. It certainly could do no harm, for who would deny that charitable institutions, like individuals, become lax, with sometimes tragic consequences.

T. W.

Washington Physicians of Yesterday—Morgan

(*Continued from page 708*)

Dr. Morgan had distinguished ancestry. His father was Dr. James Ethelbert Morgan (1822–89), who for forty years was one of the most eminent and active physicians of Washington; and he had a brother, Dr. Ethelbert Carroll Morgan (1856–91), whose promising career as laryngologist was prematurely cut short. His mother, Nora Digges Morgan, was derived from the famous Digges and Carroll families of Colonial origin. The residence of her father, William Dudley Digges, a descendant of Governor Edward Digges of Virginia, was located at Green Hill, in Chillum Manor, Maryland, a short distance outside of the District. Pierre Charles L'Enfant, the famous French engineer who laid out the plan for the city of Washington, in his old age became impoverished and destitute, and was befriended and cared for by members of the Digges family; and at his death in 1825 he was buried in an unmarked grave in the garden at Green Hill. Being thus personally interested in the case, Dr. Morgan after fourteen years of effort to that end succeeded in having the remains of L'Enfant removed by the Government in 1909 from Green Hill, and reinterred, with elaborate ceremonies, in Arlington Cemetery in a worthy final resting place in front of the Mansion.

Dr. Morgan had a strong avocational interest in historical matters, which was quite natural in view of the interesting and noteworthy historical associations which he and his ancestors had. He became one of the earliest members of the Columbia Historical Society, in 1894, and was its Treasurer 1896–1901, and its President 1909–16. Ranking high among local historians, he was well versed especially in the early history of the District of Columbia, contributed articles on the subject, and presented to the Library of Congress an extensive mass of letters, documents, and other historical material in that field.

John B. Nichols, M.D.

MEDICAL ANNALS OF THE DISTRICT OF COLUMBIA

VOLUME XVI, 1947

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